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FUTURE DIRECTIONS
FOR HEALTH CARE IN SASKATCHEWAN

Summary

Saskatchewan Commission on Directions in Health Care

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A Province in Transition

Society has changed profoundly since Saskatchewan's health care system was designed. A system redesigned for the 1990s and beyond must reflect the changes which have occurred, particularly in this province. These changes, which have been rapid and extensive, have affected the kinds of demands that are made on the system and the way in which services are delivered.

Changes in Society

Perhaps the most pronounced trend across the province in the last 30 years has been the shift in population from rural Saskatchewan to cities and towns. Since the early 1960s, the number of people living on farms and nearby communities has dropped from more than 50% of the total population to about one-third today, and in another 20 years it will fall further, to below 20%.

In that same period, Regina and Saskatoon grew by 65% and the remaining cities by 44%. Further rapid growth is projected.

There has been a very significant increase in the number of older people in the province during the past few decades, and a decrease in the number of younger people. Saskatchewan has the highest percentage of people in the 65-plus group of any province, and the fastest-growing segment of its population is those who are 85 years of age and over.

Today people 65 and over make up 13% of Saskatchewan's population, but in most towns of 2,000 or less, between 30% and 40% of the residents are in this age group. This percentage will continue to grow.

Population statistics in Northern Saskatchewan are dramatically different from the rest of the province, however. Up to one-half of the residents of most northern communities are 20 years old or younger, while in some communities only one in 25 is 65 or older.

Family size has decreased in the past few decades in Saskatchewan and is expected to drop further as the number of births per woman decreases from the present 2.1 to 1.85 within the next 20 years. Among other things, this will affect the need for obstetrical and pediatric services.

There has been a dramatic increase in the number of single-parent families. The standard of living of such families often falls, raising concerns about healthy eating habits and lifestyles; the result often is an increased need for professional services and medications.

The increased visibility of family stress and violence in our society, and increased sensitivity to such problems, demand that better support and protection be made available, along with more counselling and rehabilitation services.

The increasing number of seniors in the total population, and the increasing number of seniors living on their own, results in more demands for and expectations of community support systems. Statistics indicate that 33% of aged, unattached individuals fall below the poverty line. Such people are more likely to fall ill because of poor nutrition, and also are more likely to lack a support system.

Poverty is one of the best predictors of who will need health care. The number of Saskatchewan people living below the poverty line appears to be on the increase, with 22% of families now in this category. One of every four children is part of these families.

Living conditions and societal circumstances have contributed to dramatically higher incidences of infectious diseases and of alcohol and drug abuse among residents of Northern Saskatchewan. The incidence of serious injury is also greater than among residents of the south.

Throughout the province, people's expectations of the health care system have risen significantly, too. These expectations include the delivery of outreach programs to the smallest and most remote communities, the solving of most health care problems by improved expertise and technologies, and more immediate responses to all demands.

Changes in Patterns of Illness

Infectious diseases have virtually been eliminated in southern Saskatchewan by mass inoculation programs, but they have been replaced by chronic diseases requiring extended treatment. Such chronic diseases reflect the aging of the province's population and frequently fall into the cardiovascular, degenerative and malignant categories. The demand for services related to disabling orthopedic, circulatory and visual disorders has also increased as the number of elderly has risen.

Up to March of 1990, 33 cases of AIDS were reported in Saskatchewan, with 20 deaths. The rate is expected to continue to rise and it is projected that, nationally, the number of cases will double every 20 months; this has dramatic implications for medical and hospital services.

Many diseases and ailments have a higher incidence among the northern population than in the south. For example, respiratory diseases were six times greater and injury and poisoning three times greater among children in the North.

Changes in Delivery Systems

The medical and hospital systems which developed in Saskatchewan met the needs of a population spread widely across the province, with only one-third of the people concentrated in the cities. As described, the situation has changed enormously.

Because of the shift in population and the changing delivery patterns and consumer expectations, the number of physicians practising in solo practices in rural Saskatchewan has decreased, but there are still 57 communities with one physician and 26 with two. Almost all of these physicians were trained outside Canada.

The number of physicians licensed to practice in Saskatchewan has continued to rise, and is approximately 1,500 in 1990. Statistics show a correlation between the number of physicians and the use of physicians, drugs and hospitals. A growing percentage of the population visits physicians, and the number of physician services used per 1,000 people has increased for every age group.

The consumption of prescription drugs, too, has increased, especially during the 1980s. The costs of the Saskatchewan Prescription Drug Plan doubled every three years from 1981 until 1987 when the Plan was changed, while the number of prescriptions processed rose by 6.1% each year.

Saskatchewan has more hospitals than any province except Ontario and more beds per 1,000 people than all provinces. There has been a continuing increase in the occupancy rate of the largest urban hospitals, and a continuing decrease in the use of smaller hospitals. As a result, about 40% of the beds in the smallest rural hospitals are never used while the demand on the large hospitals continues to grow.

The high ratio of hospital beds to population has been an incentive to put people in hospital at a greater rate than other provinces; most recent figures are 1,754 patient-days for every 1,000 Saskatchewan people compared to the national average of 1,425. Utilization of long-term care beds in the province is also high, and there are plenty of those beds: 171 beds for every 1,000 people over 75, compared to 163 nationally.

The open-endedness of the health care system has contributed to increasing demands for taxpayers' dollars to finance it. Over $1.4 billion was allocated to health in 1989-90, more than $1,400 for each Saskatchewan resident, and that figure was raised by $100 million for the 1990-91 fiscal year.

Principles for Change

Basic Principles

Universality
– equal care for everyone

Comprehensiveness
– a full range of services

Accessibility
– no barriers to quality care

Public Administration
– a publicly-owned, non-profit system

Freedom of Choice
– ability to choose provider

Responsibility
– a purposeful use of the health system

Expanded Principles

Sense of Ownership
– local control and accountability

A Provincial System
– a unique Saskatchewan character

Focus on Health
– emphasis on maintaining good health

Professional Teamwork
– interdisciplinary approaches in delivery of care

Effectiveness
– focus on outcomes and results

Adaptability
– openness to new ideas and options

Affordability
– getting the best value from resources

Consultation
– sensitivity to expectations and concerns

A Consumer-Controlled Health Care System

Underlying Considerations

Mainly because it is compartmentalized into many distinct and unrelated "packages", the health care system is frequently not seen as a "whole" by consumers and providers of services. Responsibility for these "packages" lies with different sizes and types of independent boards and agencies, and their numbers cause considerable confusion for consumers who, from time to time, wonder about the possibility of some amalgamation and redefinition of territory. They also wonder why certain programs are the responsibility of local boards while others are delivered directly by the government.

The lack of any real continuum of care in Saskatchewan has been identified as a serious obstacle to uninterrupted services. Consumers ask why there is not more co-ordination and interdependency among the parts of the health care system.

It is evident that there is insufficient accountability by decision-makers to the people who use the system and provide the financial resources to sustain it. They feel no sense of ownership for the present system, no control over it, and no way to make those who run it accountable. Members of boards in the health care field may be appointed by the Minister of Health, by local government, or by a combination of agencies. Rarely are they elected.

The politicization of the health care system has caused concern about the possibility that objective criteria may not always be used in making decisions about long-term directions and priorities in the allocation of resources. Health care, more than any other social program, gets buffeted about in the political arena.

Proposed Directions

- Establishment of 15 health services divisions to manage the total system and deliver the complete package of services, including community-based, home care, mental health care, and acute and long-term institutional care.
- Establishment of division councils of 10 to 12 members elected by residents of the health services divisions.
- Assignment of full fiscal management and staffing responsibility to division councils to ensure that health care services are delivered effectively and responsively to meet the needs of their residents.
- Development of health funding policies which provide more flexibility in the allocation of funds, incentives to encourage the consideration of new and more efficient systems for delivering services, and a process which focuses on the outcomes and results of such services.
- Development of policies by the Department of Health which ensure that accessibility, universality, comprehensiveness, affordability and quality of health care exist equitably throughout the province.

Emphasis on Community and Supportive Living Services

Underlying Considerations

Community health services, once the major element of the provincial health program, have not kept pace with other developments in health care and have received a decreasing share of the budget year after year. This "slippage" in funding has been most dramatic in the field of mental health services.

As well, there has been no comprehensive or clearly-outlined system of services to provide adequately for those who become mentally ill, and consequently they face a program lacking continuity and certainty. Thought of as "someone else's problem", the mentally ill truly are the forgotten constituents.

Different agencies have responsibilities for community health programs which are provided to the elderly and those provided to pre-school and school-age children. Other agencies deliver community and supportive services to the handicapped, and still others to the mentally ill. This results in overlapping services and an ineffective use of professional resources.

There are more and more expectations of rehabilitative and supportive living services, and more importance is attached to helping the elderly and disabled continue to live independently. This is particularly true in rural Saskatchewan. Such expectations are frequently expressed by senior citizens who suggest that institutionalization must be a last resort.

The time has arrived for society to identify its goals for an improved quality of life and the means necessary to achieve it. The emphasis must be more on health, rather than health care.

Proposed Directions

- Identification, by the Department of Health for the province, and division councils for their divisions, of explicit health targets to serve as the basis for development of strategies and programs to reach those targets, and a commitment of funding to ensure they are achieved. The targets should be set for five-, 10- and 15-year periods.

- Development and adoption by each division council of a comprehensive, co-ordinated and integrated program of community health and supportive living services focused on promoting health and fostering independent living. The program should include public health, mental health, home care, chiropody, community therapy and health promotion.

- Adoption of a team approach to the delivery of community health services by nurses, nutritionists, health educators, mental health workers and community therapists to provide a co-ordinated program to the total population regardless of age, circumstances or location. For example, a community health nurse should be able to offer services to pre-schoolers, seniors and all ages in between.

- Establishment in each division of therapy services units staffed by physical therapists, occupational therapists, speech and language pathologists and support personnel, which would provide services on an outreach basis in community hospitals, supportive care centres, family health care centres and private homes.

- Increased emphasis on the home care component of a community-based program, to provide services to all residents who require home supports to remain independent and in the community for as long as possible, including the elderly, the young disabled, the mentally handicapped, the mentally ill and those with head injuries. Such services should include nursing, home support and rehabilitation.

- Implementation of a program of supports to the family caregiver, which would ensure the availability of counselling and educational support, as well as access to respite and adult day/night care services.

- Creation of a Saskatchewan Mental Health Commission for the purpose of recommending initiatives in mental health, monitoring services, establishing standards, sensitizing the public and decision-makers regarding mental health issues, and serving as an advocate for both mental health clients and service providers.

- Assigning to division councils responsibility for all mental health services, those which are community-based and those that must be provided in institutions.

- Redefinition of mental health institutional care, creating specialized institutions in Regina and Saskatoon to serve the total population and developing primary mental health care centres in each division to provide basic and shorter stay services closer to home.

New Thrusts for Institutions

Underlying Considerations

Many circumstances have changed in society generally, and in the delivery of health care services specifically, which affect the use of health care institutions by Saskatchewan citizens. The mandates of these institutions require redefinition so they can serve the needs of the population more adequately and appropriately.

Using rural health care institutions less than in the past is the obvious preference and trend today, prompted by several factors, including the increased sophistication of the services delivered, which requires more centralization; increased expectations about the availability of the most sophisticated techniques and advanced specialization; and people's desire to maintain an independent lifestyle in their own homes for as long as possible.

Saskatchewan has more acute care and long-term care institutions and beds in relationship to population than any place in Canada, and still more are planned. Because they exist, there is a tendency to use these institutions to accommodate people without examining their need for institutionalization. As a result, the dependence on hospitals and nursing homes, particularly in smaller communities, has not declined despite the growing use of alternatives to institutional care.

It is particularly important to find ways to revitalize the institutions in smaller communities, so they can serve more meaningful purposes which respond to the needs of the local population. In many cases, up to 40% of that population consists of people 65 years of age and over. Is it possible for these institutions to take on the role of enhancing independent life and promoting health and well-being among their local residents?

The lack of inter-relationships between long-term and acute care institutions on the one hand, and larger and smaller acute care institutions on the other, is of special concern. Institutions frequently lack defined mandates which would let them complement each other and enhance the ability of the smaller facilities to serve their immediate communities effectively.

Because of the comprehensiveness and sophistication of the services they offer, the base hospitals in Saskatoon and Regina have a special responsibility to develop plans for more rationalization of clinical services among them and to undertake joint ventures.

Much inconsistency is evident about who gets admitted to a hospital and how long they stay. This suggests that people may be admitted when they don't need to be.

A rationalized and centralized medical transportation system is crucial to efforts to provide appropriate support and complementary services to those available in Saskatchewan hospitals. The fact that there is considerable independence between hospitals and ambulances gives rise to certain problems.

Proposed Directions

- Categorization of all hospitals in the province to reflect the services they are required to provide, and their relationships to each other. Mandates for each category and links between them must be clearly defined and take into account medical, technological, demographic and geographic factors.

- Redesignation and redefinition of the hospitals in the smallest communities into new multi-purpose facilities known as family health care centres which would provide a broad range of primary outreach, out-patient and other services, in keeping with the changing health circumstances of the local population.

- Redefinition of the roles and relationships of the base hospitals in Saskatoon and Regina to increase the rationalization of clinical programs and the co-ordination of hospital services. Without affecting the ownership of the hospitals, the target to be aimed for is the concept of a "Saskatoon Hospital Complex" and a "Regina Hospital Complex".

- Designation of one division hospital in most divisions, or in some instances of two hospitals as co-divisional hospitals, to provide a reasonable range of secondary hospital services to division residents with minimum travel required. A crucial objective must be to enhance the roles of these hospitals through formal partnerships with base hospitals and the College of Medicine.

- Designation of hospitals with average acute care daily censuses between 10 and 40 as community A or community B hospitals depending on size, population and services available. The services offered would be enhanced through links with division hospitals.

- Formation of a Provincial Hospital Utilization Management Committee which would develop admissions criteria to be used in hospitals throughout the province and enunciate medical practice protocols to ensure the best utilization of all categories of hospitals.

- Redesignation of all nursing homes and special care homes as supportive care centres to better reflect their mandates, and preparation of uniform standards to determine staffing levels and program components for heavy long-term care residents.

- Establishment of a target ratio for numbers of heavy long-term care beds in proportion to population served, with special attention to the needs of the severely cognitively impaired. The institutional program for the cognitively impaired should be modified, and emphasize supportive interpersonal relationships and compassionate care.

- Development of a comprehensive and co-ordinated medical transportation system which ensures a wide range of high-quality and cost-effective emergency and non-emergency transportation. It should have its headquarters in the division centre with an interlocking network of road ambulance and auxiliary transportation services in smaller communities, and centralized dispatching from the division hospital.

New Approaches for the Health Professions

Underlying Considerations

The introduction of Medicare in the early 1960s laid the foundations for the way in which medical services would be delivered in Saskatchewan. It contributed significantly to a degree of independence and exclusivity, by determining on one hand how services are delivered and, on the other, by whom.

Concerns have been expressed about the system of payment for physician services, which is said to sometimes detract from the practice of "quality" medicine. It may even encourage excess in the number of services provided or medications prescribed.

In this province, the availability of physicians is a constant concern, particularly with general practitioners in rural Saskatchewan and specialists in the larger centres. The situation is complicated by the fact that graduates of Canadian medical schools consider medicine is practised best in partnership with other physicians rather than alone. Specialists want opportunities to use their skills to the fullest degree possible and to have modern technologies available to them.

The nursing profession is in transition. The demands and expectations expressed of nurses suggest that they need to assume more professional responsibility, but structures, policies and traditions frequently stand in the way. It often happens that while professional responsibilities increase, the least professional tasks are not passed on to someone else.

There are concerns about the numbers of people available in several other health care professions, particularly psychiatric nurses, physical and occupational therapists and speech and language pathologists, and especially about the lack of such services in rural Saskatchewan.

Many of the educational programs for health care professionals were developed before the most profound changes took place in systems and programs. The institutions offering these programs may not have been given the opportunity to make substantial-enough adjustments to keep pace with the changes. There appears to be a need to discontinue some programs, to modify others, and to add new ones.

Proposed Directions

- Restructuring of legislation and the payment system to encourage the development and introduction of different medical practice models, including the encouragement of group practices, particularly in smaller communities.
- Establishment of medical services centres with teams of health professionals providing basic medical services and complementary health care.

- Adoption of stricter provincial regulations concerning the establishment, operation and ownership of auxiliary and supplementary clinics, and limits on the kinds of involvements physicians may have with such clinics.

- Development by the Department of Health and division councils of a long-term plan which identifies provincial and division requirements for specialists and general practitioners, and spells out training opportunities and recruitment strategies.

- Adoption of a "mandate of the future" for the College of Medicine at the University of Saskatchewan, which clearly reflects the Saskatchewan setting, anticipates advances in technology and specialty services, and addresses the need for interdependence and complementarity of roles with other colleges of medicine.

- Redefinition of the scope of nursing services to reflect increased professional responsibility and new circumstances which provide more opportunity for nurses to become more equal partners in the delivery of medical and hospital services. In certain settings, particularly rural Saskatchewan, nurses might become "gatekeepers" to a greater degree.

- Restructuring of the registered and psychiatric nursing programs to provide more co-ordination between different training institutions, thus ensuring that increased opportunities exist to enter university, and to provide for more specialization.

- Establishment of a strategy which would produce expanded therapy services throughout Saskatchewan, with special emphasis on the training of physical and occupational therapists at a new school of rehabilitation sciences.

- Establishment of a Health Sciences School for Continuing Education which would actively involve each health science faculty at the University of Saskatchewan and the Saskatchewan Institute of Applied Science and Technology in developing a sophisticated, comprehensive and co-ordinated long distance education program providing in-service and credit courses.

- Recognition of the expanded roles of supportive health care professionals in providing a comprehensive health services package in both community-based and institutional programs.

Provincial Programs in a New System

Underlying Considerations

The proposal to delegate considerably more control of the total health care program to division authorities affects the role and relationships of the Department of Health. However, the Department will always have to be concerned about the quality and availability of health services throughout the province, and must continue to set the standards.

Because of the complexity of the health care system, it is particularly important to ensure a high degree of co-ordination and consistency among the various components of the system and in the ways in which programs are delivered.

The universal nature of certain programs makes it necessary that they be delivered directly by the Department of Health in a way which ensures accessibility and affordability. Yet, policies and practices must be put in place to ensure a high degree of responsibility among both consumers and providers.

It is especially evident that many of the services which have been developed and many of the priorities which have been established did not take into adequate consideration clearly-identified needs and well-defined outcomes.

Proposed Directions

- Enhancement of policies and practices which ensure that all children throughout the province have easy access to dental services under the Children's Dental Program, and that adequate control is maintained on the supply of prescription drugs to the Saskatchewan market.
- Redefinition of roles and responsibilities for agencies providing alcohol and drug treatment, cancer treatment, laboratory and poison control services.
- Designation of certain special institutions with mandates which are provincial in scope as Crown institutions, with government-selected boards to manage them.
- Creation of an autonomous Health Analysis and Development Commission which reports directly to the Legislative Assembly, and which has provincial responsibilities to monitor and analyse health programs and practices, determine their effectiveness and efficiency, and recommend policies to the government and division councils.
- Development of initiatives at three levels - divisional, provincial and interprovincial - for research, study, analysis and education in the field of health care ethics.
- Increased rationalization of services of non-government organizations with appropriate sources of funding determined between provincial and local levels and more mechanisms for accountability for use of public funds.

Better Health for Northern Residents

Underlying Considerations

The northern half of Saskatchewan differs dramatically from the rest of the province in its economic, geographic, historical, social, demographic and cultural factors, and these combine to pose serious and unique problems in health care delivery.

In many respects, the most pronounced problem - which has a profound effect on the health status of northerners - is an economic one. In some communities, the unemployment rate is as high as 90%, which has a direct bearing on standards of living.

A much higher incidence of infectious diseases is evident, particularly respiratory conditions, tuberculosis, middle ear diseases and sexually transmitted diseases. The high incidence of alcohol and drug abuse has a harmful effect on the health of individuals.

There is an evident lack of consistency and continuity in the health care services available to residents of northern communities. Because of frequent difficulties in recruiting personnel, certain positions remain unfilled for periods of time, interrupting the availability of services. As well, the ratios of professional staff to population fall below those in southern Saskatchewan.

The need to upgrade institutional care and medical transportation services is obvious. There are very few specialized acute care services available and no long-term care institutions. There is no specific plan to provide economical and efficient medical transportation services.

At the same time, the need to expand community-based and mental health services and make them systematic is evident. They are now delivered in a way that lacks consistency, equitability and continuity.

There is evidence of growing impatience among northern residents that they have very little control or responsibility for the health care system. The fact that local residents are capable of assuming far more responsibility for the management and delivery of health care services must be recognized.

Proposed Directions

- Establishment of three major health services divisions, which take into account geographic, transportation and cultural factors, for the purpose of managing and delivering a total package of health care services.
- Establishment of division councils, with representatives from the established communities and reserves, which have authority and responsibility for the provision of community-based services, home care, mental health services, acute and long-term institutional care, and medical transportation services.

- Creation in each division of a network of health care facilities consisting of a multi-purpose division hospital, comprehensive family health care centres, satellite outreach clinics and funded personal care homes.

- Expansion of a community-based program with an enlarged complement of public health professionals, and native community health workers and assistants.

- Establishment of medical transportation services headquartered at the division hospitals with satellite stations in other centres, and an air ambulance unit based in La Ronge.

- Development of a manpower service program which includes special recruitment and retention initiatives and special professional training opportunities in the health care field for residents of the North.

- Definition of the special responsibilities of the Northern Health Services Branch of the Department of Health, which would result in it working closely with division councils, and establishment of mechanisms to significantly increase the consolidation and co-ordination of federal and provincial services.

Commentaries on Health Care Issues

Caring and Compassion

Despite sophisticated delivery systems and advanced technology and specialization, there will always be those in society for whom complete treatment or recovery is not possible. They are the ones who carry the greater burden of suffering and unavoidably make special demands on society and on their families. The health care system must be responsive to these people, and caring of them. It must ensure that efforts are always made to find a cure or to relieve suffering, while at the same time providing the necessary supports and conditions which ensure that caring for those who are chronically ill or who suffer from some rare disease is characterized by compassion and understanding.

Environment

There is increasing knowledge and awareness that the earth's environment has deteriorated to a dangerous state of fragility, and evidence which suggests that the pace of environmental deterioration is accelerating. This environmental degradation has a direct effect on personal and community health, yet very few effective means have been adopted to change the situation. Emphatic and demanding rules must be set down to ensure that the factors detrimental to good environmental conditions are corrected promptly, or prevented in the first place. There is a profound need for imaginative and aggressive action on the part of individuals, governments and industry. There is no time to wait to be told what to do. We must start doing it!

AIDS

AIDS is a new disease phenomenon. It is a disease with a special social dimension. It springs from human actions and is frequently caused by lack of concern, caution or awareness. It is obviously going to affect an increasing number of victims. Very special efforts are required in terms of how AIDS is treated, how we educate the public about it, and how we relate to and care for its victims.

Abortion

Abortion is much more than a health care issue; it is a moral and ethical issue. Moral and ethical considerations are the basis for determining the actions to be taken for many other conditions and in many other circumstances. However, none is as divisive or contentious as abortion. It is not the responsibility of the health system to determine what society wants to do about abortion. Its responsibility is to respond in the most effective and appropriate manner once the principles have been set down by society.

Midwifery

The need for support, encouragement and understanding as part of the medical service available to women during pregnancy and delivery is increasingly appreciated. Childbirth should occur in the presence of people who provide personal support to the mother, and it is in this context that the midwife is seen to have a role. However, there also is increasing appreciation of the importance of specialized knowledge, and expectations that resources will always be available to deal adequately with the most complicated circumstances. Thus, the place of midwives must be considered in terms of knowledge and training which could make them valuable members of obstetrical teams.

Medicine Men

Within the culture of the Indian population, the medicine man provides a special service that touches on the meaning of life and on the relationships between an individual and the realities which are beyond him or her. It is a very personal service which cannot be defined within constrictive parameters because it will vary with persons and with circumstances. However, it must be recognized as important, and it must be seen as complementing the scientific and clinical approaches used by the formal health care system in our society.

Smart Card

The "micro-chip" technology is expanding. Its potential is still being discovered and its application to the health care system is being investigated. There are some very strong indications that this technology, through what is known as the "smart card", can serve the interests of individuals very effectively in terms of treatments, responses and records. It can ensure that medical and hospital services are quickly and appropriately delivered to meet the unique circumstances of the individual involved, and can enhance the evaluation and analysis of procedures and outcomes.

Employment Conditions and Benefits

In the proposed reorganization of the health care system, careful consideration must be given to the impact of the changes recommended on employees who now work for a variety of institutions and agencies within the system. Special thought must be given to protecting seniority, security, employment benefits and pay levels that are reflected in a variety of contracts. It appears that the best interests of employees within the system, regardless of where they are located, might be served by negotiating provincial contracts.

FUTURE DIRECTIONS
FOR HEALTH CARE IN SASKATCHEWAN

Saskatchewan Commission on Directions in Health Care

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Copies of the complete report and summary are available from:

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90-04337/

Honourable Grant Devine
Premier of Saskatchewan
Legislative Building
REGINA, Saskatchewan
S4S 0B3

Dear Mr. Devine:

In accordance with the Order-in-Council 465/88, we are pleased and honoured to submit to you "Future Directions for Health Care in Saskatchewan".

Each one of us appreciated the opportunity to participate in this major review of Saskatchewan's health care system, and we express our sincere hope that our report will result in a restructured and revitalized system which will better serve the residents of Saskatchewan.

Yours sincerely,

RGMurray

Dr. R.G. Murray
Chairman

Walter Podiluk
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PREFACE

The Saskatchewan Commission on Directions in Health Care was appointed by the Premier of Saskatchewan effective July 1, 1988, and given the mandate to:

1. Investigate a full range of issues affecting the quality, availability, accessibility and cost of health care services, with particular consideration of the differences between rural and urban communities;
2. Identify and give priority to emerging and long-term issues affecting health care delivery;
3. Recommend policy options to the government on:
   (a) ways to improve health care delivery and the efficiency of the system while maintaining quality and accessibility of service;
   (b) management of future health care delivery needs including funding and servicing, education, technology and training requirements.

The Commission's task was to inquire into and report on future health care requirements in the following specific areas, plus others as they were identified:

1. Institutional treatment and support services such as hospitals, special care homes, ambulances and home care;
2. Insured services such as medical and dental services and drugs;
3. Community health services such as public health, mental health and health promotion;
4. The impact of social factors such as demographic trends, changing lifestyles and consumer expectations on the need for, and delivery and costs of, health care;
5. The supply, education, qualifications and distribution of health care professionals and paraprofessionals;
6. The nature and distribution of health care facilities and services;
7. The efficacy and cost-effectiveness of new technology in diagnoses and treatment;
8. The organization and delivery of health care services, with emphasis on equality of access and cost-effectiveness;
9. The communication of health information, illness prevention, and the education of the public in personal health matters;
10. The assurance of quality in all aspects of health care;
11. The utilization of health care services;
12. Funding processes for health care services.

In undertaking its task, the Commission adopted a five-phase action plan:

1. **Orientation**, which included getting an overview of Saskatchewan's health services, examining health care issues from a broader perspective, and participating in a meeting with provincial premiers.

2. **Dialogue**. During this phase the Commission had an opportunity to gain an in-depth understanding of issues and to share perceptions and ideas with health care providers. This phase involved meetings with key health care organizations and individuals in Saskatchewan, as well as with the Alberta Health Care Commission.

3. **Consultation phase**, during which public hearings were held in 13 Saskatchewan centres over 41 days, and more than 450 briefs were presented publicly. The public hearings were so well attended that the Commission's original schedule had to be extended. Commissioners also held forums involving special interest groups, met privately with some groups by request, and arranged tours and visits to selected communities and health care facilities, including visits to nine northern communities.

4. **Analysis phase,** during which briefs, submissions and presentations were reviewed, follow-up discussions were held with groups and individuals for clarification and elaboration, and general directions and parameters were developed for the report.

5. **Finalization phase**, which included touch-base meetings with various groups to obtain feedback on positions and ideas, determination of final positions on various issues, decisions on the components of the final report, and preparation of the report.

EXECUTIVE SUMMARY

Executive Summary

Change - in the way and where Saskatchewan people live, in the age mix among those people, in the kinds of illnesses they suffer from, in the way health care is provided to them and the way it is used - was the first subject the Saskatchewan Commission on Directions in Health Care concentrated on when it began the task given it by the Premier.

This change has made the health care system outdated. Saskatchewan is today a province of city and town dwellers, and has a large and growing elderly population. It has a huge North with a small population who prefer to live there but are no longer willing to suffer deprivation to do so. The health care system is in many ways still geared to a province of many small family farms with little villages spotted among them, and despite the devoted efforts of many people, it has served the North poorly. It has a confusing number of boards and districts and regions which often overlap.

Matching health care with the modern Saskatchewan thus became the Commission's goal. But it was conscious that the province has a health care tradition which cannot be abandoned; its system has been built on principles firmly and almost universally held. In confirming its allegiance to those principles, the Commission blended them with new principles which are their outgrowth. Together, they are the foundation of the new health care system proposed here for Saskatchewan.

The basic building block of this new system is the idea that the people it serves must have ownership and responsibility for their local health care system, must determine how it is used and managed, and establish its priorities. The Commission is recommending a system divided into health services divisions governed by powerful councils that are locally elected and funded mainly through the Department of Health. These councils would be responsible for putting together the broad-based package of health care services required in their area, uniting under one umbrella health protection and promotion, community-based services, institutions, ambulances and more.

The Commission believes that the focus on health care will in future be superseded by an emphasis on health, and lays new importance on the need for health objectives to be spelled out and worked towards. It sees more stress being put on the need for people to assume more responsibility for their personal well-being, in terms of the quality of their lives and their personal efforts to maintain health. That will be one of the factors stressed in the package of community-based services it lists as a major responsibility for its new councils, along with promotion of health generally and prevention of illness and the community factors that contribute to illness. Such services are aimed at helping people continue to live normal lives in their own homes for as

long as possible, just as they are planned around the mainstreaming of mental health services.

Though it is convinced that the health care system must look at ways of reducing people's dependence on institutions, the Commission knows that such institutions will remain a crucial part of the system. It therefore considers it important that their mandates be examined and new relationships among them determined, to ensure they complement and supplement each other and share resources and personnel. In many cases, their mandates must be redefined to ensure they serve a purpose related to the people who live in the area.

The Commission recognizes the invaluable kinds of services which Saskatchewan's health care professionals have always offered, but it also sees that their roles are changing and that in too many cases, they haven't found a way to work together. It proposes that health care professionals must now offer their services in interdependent teams built in a variety of ways, makeups and sizes. It calls for new arrangements for the delivery of services by physicians, and broader and more professional roles for nurses, the largest group of health practitioners. Independent and allied and ancillary professions are included on the teams, each with its own role linked to the others. The Commission makes proposals for paying some of these health care professionals in different ways, and for new ways of training them.

The delegation of responsibilities to health services divisions and their councils opens the way to a new role for the Department of Health, a role with new partnerships and responsibilities for it to lead in new directions. It must work with its new partners in supportive ways to ensure the standards of health remain high, care is delivered in the most effective manner, and all the health care principles are adhered to. It must provide expertise to the division councils, and develop policies and strategies, goals and objectives in such fields as manpower planning and laboratory services.

The report recommends the establishment of several new provincial bodies. To keep Saskatchewan at the cutting edge of developments in health care, a Health Analysis and Development Commission is proposed. To act as a resource in a troubling area, a Prairie Centre for Health Care Ethics is envisioned. Among the directions recommended in the field of mental health is the creation of a Saskatchewan Mental Health Commission.

Northern Saskatchewan was perhaps the most challenging part of the Commission's work, and its recommendations are sweeping. They are based on the principle that the

North must have access to the same kind of quality health care services as the rest of the province, and that northerners must be deeply involved in making sure this occurs. Northern health care, too, must be locally controlled and managed and arranged to meet local needs. Particular recommendations are made for recruiting health care professionals for the North, and to encourage northerners to prepare themselves to become such health care professionals.

In this report, the Saskatchewan Commission on Directions in Health Care has proposed a major restructuring of the health care system. It recognized the soundness of the founding principles of the system of today and has used them as the basis for proposing new principles, structures and directions.

A. CONTEXT FOR CHANGE

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1. A Province in Transition

Dynamics of Change
Changes in Society
Changes in Patterns of Illness
Changes in Delivery Systems

Dynamics of Change

Change appears to be the only constant factor in today's society. Never before in human history has change been more profound or more rapid or more inevitable; the increasing creativeness of the human mind will not stop and wait for individuals, institutions, organizations or services to catch up.

Change takes on a special character in Saskatchewan because this province constitutes a unique society formed by its geography, its history and its people, as well as the mix of all these factors. Change has had a profound and unique effect on every aspect of our lives here and it will continue to do so in the future. Every institution, every program, every service, whether public or private, must change as society changes. Those institutions, programs, services or systems that fail to keep pace lose their vitality and effectiveness.

Looking into the future at a health care system that will serve the residents of this province in the years ahead, the Commission first looked at the past and examined the present. It identified the major factors that promote change in the health care system we have built over 40 years. These include changes in society, changes in illness patterns, and changes in the delivery of health care. As it projected into the future over the next two or three decades, the Commission proposed changes for that future.

Changes in Society

The Face of the Province

Where People Live

Saskatchewan has become a province of city and town dwellers, as Figure 1 shows.

Only 30 years ago it was largely rural, with over 50% of its population living on farms and in the villages which served them, and only one-third in the nine communities then classed as cities: Regina, Saskatoon, Moose Jaw, Prince Albert, Weyburn, Estevan, Yorkton, Swift Current and North Battleford.

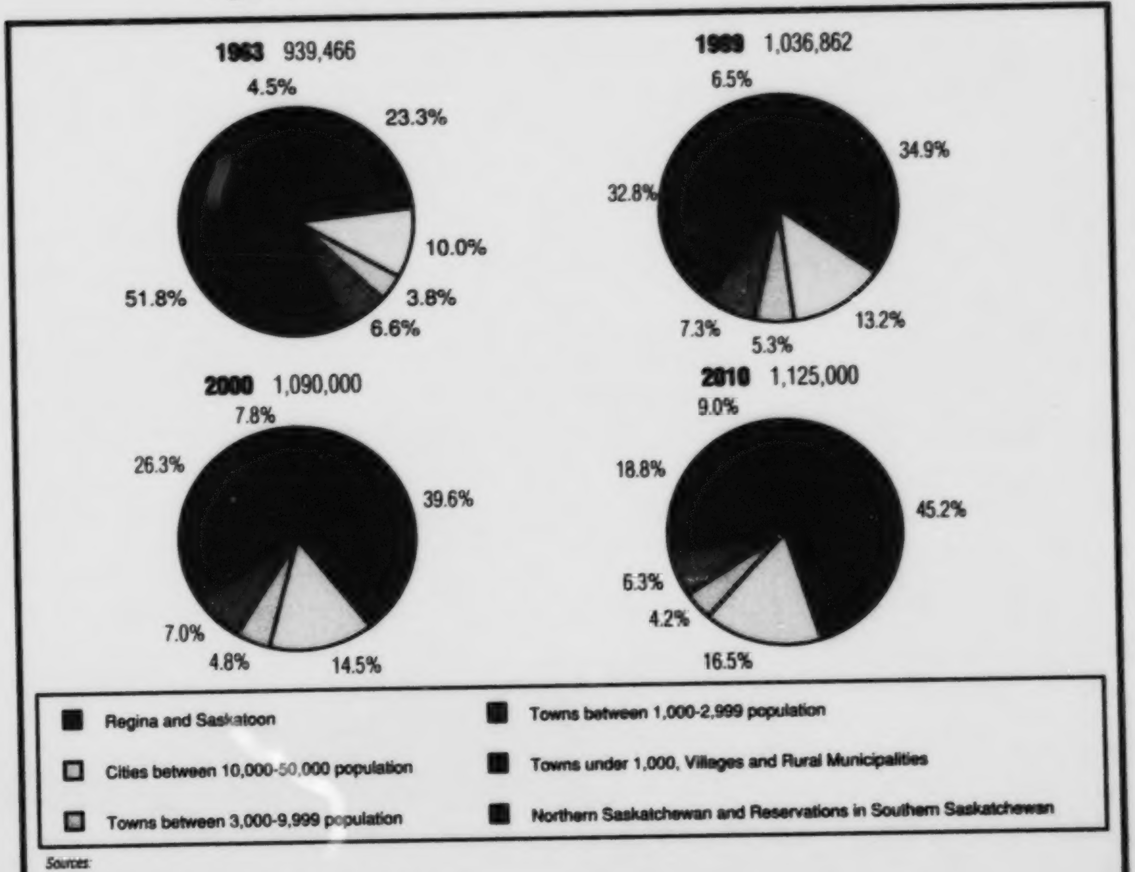
The situation has changed drastically. Farms average more than 1,000 acres today compared to 500 acres in 1960, and farmhouses filled with farm families are fewer. By 1989, only 33% of Saskatchewan people lived in rural areas and the nearby communities (Saskatchewan Health Covered Population, 1989). Nine out of every 10 towns with less than 1,000 people have been steadily shrinking since the 1960s. It may be sad, but it is also true: rural Saskatchewan is emptying.

Regina and Saskatoon have been the magnets for many of those who left, pulling almost 140,000 people to them between 1963 and 1989 for an increase of over 60%. But regional centres also grew, by 45%.

Even people who still live happily in rural Saskatchewan are going to the larger towns and the cities for their shopping, their recreation, their business, their health care. Their children go to school there. The symbol of this change is the bright yellow school bus seen everywhere on the all-weather highways that criss-cross the province - the highways that have facilitated the change.

This situation is not going to change in the foreseeable future, nor is it likely to be reversed by new development in villages. Reasonable projections estimate that by 2010, about 72% of Saskatchewan's population will be living in communities of 1,000 or more, and only 19% in rural areas and villages (based on Saskatchewan Bureau of Statistics, 1989).

Figure 1: THE MOVEMENT OF SASKATCHEWAN PEOPLE FROM 1963 TO 2010



Sources:

Saskatchewan Health Insurance Covered Population Reports 1961-1989.

Projections based on figures obtained from STATISTICS CANADA. Projection Section and from the SASKATCHEWAN BUREAU OF STATISTICS.

However, the North will contradict this pattern. Most of its communities have gained in population since 1973, mostly due to their high birthrates. Those birthrates are unlikely to change; one-third to one-half of the residents of most northern communities are under 20. Those young northerners may go south for education and training, but many of them say they want to live and work at home.

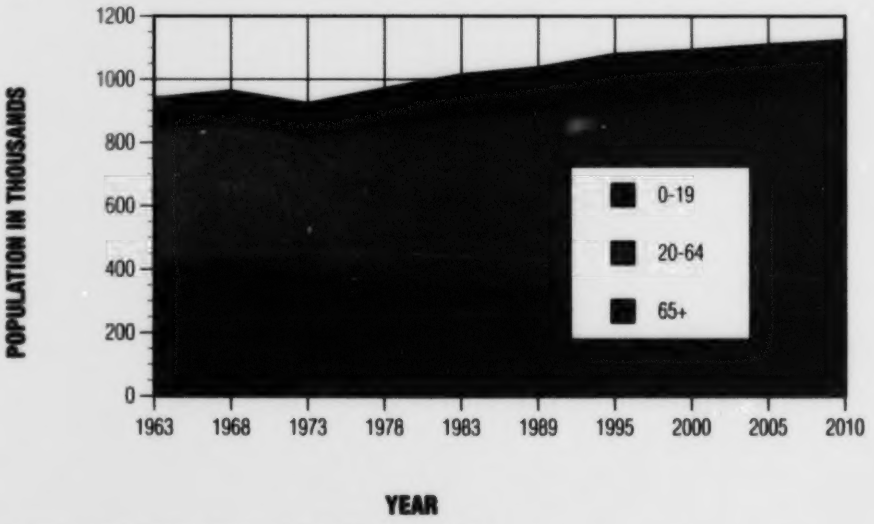
It does not take a great deal of imagination to see that this striking change in the distribution of the population of Saskatchewan demands changes in the health care system. That system still reflects the rural-urban split of 30 years ago, but the hospitals spread so generously in smaller communities are little used for acute care today. This is because an ever-increasing number of Saskatchewan residents are turning to the larger centres for all their services, including health.

Old and Young

Wherever we look, but especially in rural Saskatchewan, we see illustrated the demographic fact that Saskatchewan has an aging population, and fewer young people to enter its workforce (Figure 2).

Thirty years ago, when the population was 925,000, it was relatively young: 42% were under 20, 49% between 20 and 64, and 9% were 65 or older. By the late 1980s, the picture had changed dramatically, though the population had grown only slightly to one million. Just under one-third were younger than 20, and those in the 65-plus category had increased to 13% (Saskatchewan Economic Review, Bureau of Statistics, 1972; Saskatchewan Health Covered Population, 1989).

Figure 2: THE CHANGING POPULATION PROFILE OF SASKATCHEWAN

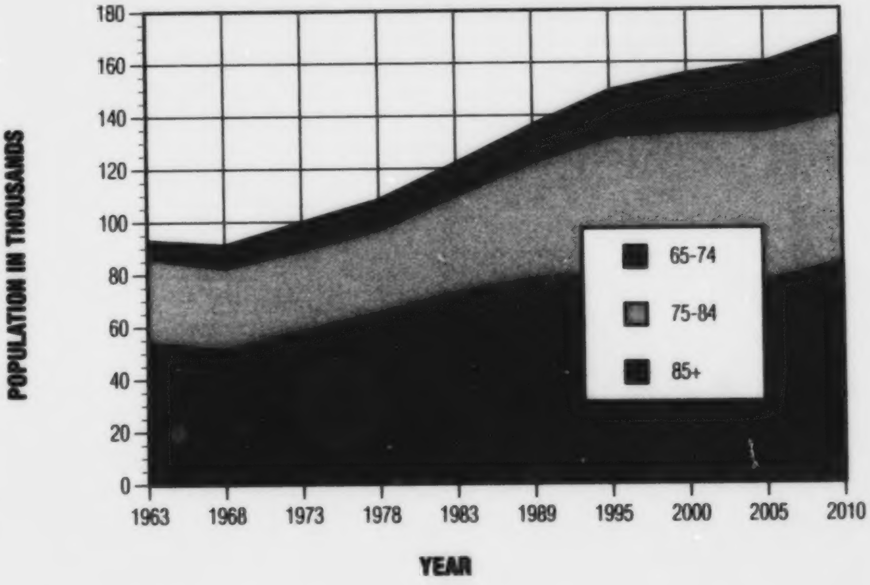


Sources: Saskatchewan Health Insurance, Covered Population Reports, 1963-1989
Projections based on figures obtained from Statistics Canada, Projection Section and the Saskatchewan Bureau of Statistics

The most striking change was in the number of old elderly, those 85 and older, now approximately 12,500 as compared to 6,800 in the early 1960s.

This trend to an aging population will continue in the decades ahead. The Saskatchewan Bureau of Statistics forecasts a population of 1.12 million by the year 2010, with just over one-quarter of those 20 or younger. About 169,000 - one out of every seven people - will be 65 or older. Almost 29,000 will be 85 or over, making this the fastest-growing segment of the population (Figure 3).

Figure 3: THE CHANGING PROFILE OF THE SENIOR POPULATION



Sources: Saskatchewan Health Insurance Covered Population Reports 1963-1989
Projections based on figures obtained from Statistics Canada, Projection Section and Saskatchewan Bureau of Statistics

A great many of those seniors will be clinging to the small communities that they have always known. Already in 1990, in most towns of 2,000 or less, between 30% and 40% of residents are 65 or older. In the smallest towns and villages with populations of less than 200, it is not unusual to find that more than half of those are seniors (Saskatchewan Health Covered Populations, 1989). Present indications are that these ratios will increase as younger people move to larger urban centres in Saskatchewan and to other provinces to seek opportunities.

The only area of non-urban Saskatchewan which will depart from this picture is the North. Even today, communities such as La Loche, Buffalo Narrows and Cumberland House have populations very much younger than those of southern communities of the same size. Those 65 and over make up only 3.9% of the populations of those three communities (Saskatchewan Health Covered Population, 1989). By 2010 the difference with southern Saskatchewan is likely to be much more striking.

Conclusion

Putting together where people live and who those people are, and projecting into the future, we see a Saskatchewan divided strikingly into three different parts, a division and a difference with enormous implications for the health care system.

We see a rural Saskatchewan emptied of most of its young people, and with fewer families living farther and farther apart on bigger and bigger farms. We see shrinking villages with the elderly making up more and more of their populations. And we see most of that rural population often on the highway, travelling to regional centres and big cities for the services they once received at home.

We see cities that continue to grow, with populations considerably younger, on average, than those in rural sections of the province, and with more and more of the services people want.

And we see a North that is different again: a mainly young population spread across a vast area, in communities which range from tiny to medium-sized towns and growing because of a high birthrate.

The Commission believes these changes and the three situations described above have many, many implications for the health care system of the future. For example, over and over, Saskatchewan seniors and their organizations told Commission hearings they wanted to live independently in their own homes, not institutions, and wanted the health care system to help them do so. Many seniors live in rural Saskatchewan, as we have seen, and that is unlikely to change. There are many small hospitals in rural Saskatchewan, but fewer of the community-based services that will help the elderly live independently.

The Family Unit

The family, too, has changed in the last 30 years. It is still the foundation of Saskatchewan society, but it's now a foundation with many different styles. Some of those changes have implications for the health care system.

Families are smaller, more mobile and less stable. They averaged only 3.2 persons in 1989, compared to 3.8 in 1960. The present fertility rate of 2.1 births per woman is expected to drop to 1.85 by the year 2010 (Vital Statistics, Saskatchewan Department of Health, 1961 and 1988). This is worrisome for a labor-intensive health care system: who will staff the hospitals and long-term care centres and provide the home care and other community-based services?

More and more women are working outside the home. In 1960, only about one-third of women were in the workforce. In 1989, just under 60% of all women between the ages of 15 and 65 were in the workforce and this percentage is expected to rise in this decade (Women's Directorate, Saskatchewan Department of Human Resources, Labor and Employment, 1990).

There have always been family stress and violence in Saskatchewan, but they are more visible today. The province's 11 transition houses gave shelter to approximately 1,100 women and 2,100 children in 1988-89 and turned away about 850 families for lack of space (Provincial Association of Transition Houses, 1989). There are many reasons for the stress that produces the kind of violence we see - from child abuse and wife battering to suicide - but it is obvious that the situation makes demands on the health care system, and especially on its community-based services.

The number of single parents has increased dramatically, from less than 5,000 in 1961 to almost 30,000 in 1986 (Statistics Canada census data, 1986). Some of those became single parents because of divorce or separation or the death of a spouse, others by having children without marriage partners.

How do such social changes affect the health system? The falling birthrate will influence the numbers of obstetricians and pediatricians and obstetric and pediatric beds in hospitals, and all the other programs aimed at the young. Single-parent families often suffer a decline in their standard of living which raises concern about healthy eating habits and lifestyles. Members of single-parent and two-career families will be even less able to care for elderly parents than is true today. And both are likely to demand health care services at hours outside of normal working hours. Unless physicians change their office hours, for example, this will mean more use of hospital emergency departments and walk-in medi-clinics.

Although most older people expect to spend their golden years as couples, Statistics Canada figures show that only 58 per cent of the elderly population in Saskatchewan in 1986 were married couples. Such mates have traditionally been each other's caregiver as long as they could be. If families can't then step in, community-based services must.

Many of Saskatchewan's elderly people find themselves better off financially than ever before in their lives, with their own resources supplemented by the benefits provided by the federal and provincial governments. But that isn't true for all of them.

Older people living on their own - as one-third of elderly women and about 15% of elderly men did in 1986, according to Statistics Canada - are not likely to be well off financially. According to Statistics Canada's 1986 mini-census, 33% of aged, unattached individuals fell below the poverty line, which ranged from $9,135 in rural areas to $11,788 in Saskatoon and Regina that year. This, too, affects the health care system. Statistics show that people who live alone are more likely to enter an institution than those who live with family. Living alone also brings with it increased likelihood of illness due to poor nutrition and the lack of a support system.

More than 85% of people over 65 had family support networks, Canadian sociologist Neena Chappell found in 1985. Tomorrow's seniors may not be as fortunate. In the prairies, as we have seen, many older people live in small rural communities and their children have moved to the cities in this and other provinces.

As family members able and willing to act as caregivers fade from the scene, community support services will increasingly have to take on that role.

Vulnerable People with Special Needs

Rapid social changes leave some people behind in poverty, and poverty is one of the important predictors of who will need health care.

Social and cultural conditions that put them behind before they start, difficulty in catching up with their more fortunate or better-placed peers, and lack of opportunities for education or job training are among the factors that make Canadians poor today. Saskatchewan has not escaped those problems. Based on Statistics Canada 1986 mini-census figures, the Canadian Council on Social Development suggests that about 22 per cent of Saskatchewan families were living below the poverty line ($9,135 in rural areas to $11,788 in Regina and Saskatoon) that year. Most importantly for the future, one in every four children was living in a family that fell below those poverty lines.

Saskatchewan people were once shocked by the need for food banks and school feeding programs in the province that prides itself on being Canada's breadbasket, but in 1990, they are facts of life in the larger cities. The Mayor's Inquiry into Hunger in Regina last year estimated that 34,000 people in that city were poor, and nearly one-third of those were children. It found that 5,500 prepared meals and 6,000 boxes of bulk food were distributed in Regina each month, and 5,000 breakfasts served. There are also feeding programs of one kind or another in schools in Saskatoon and Prince Albert, and no signs that such programs will be unnecessary in the future.

Even when they can, children often don't eat well. The Canada Health Attitudes and Behavior Survey of 1984-85 examined the eating habits of children in Grades 4, 7 and 10 in each province. Almost half of Saskatchewan's schoolchildren did not eat meals with adequate coverage in the four food groups: dairy products; breads and cereals; meat, fish or alternate protein sources; and fruit or vegetables. The staff of a Moose Jaw school, concerned about the kind of breakfast students were eating, started a program to sell milk and muffins in the school.

Northern Saskatchewan has 30,000 residents whose share of health problems is greatly out of proportion to their numbers. In many ways, in fact, the health problems of the North are similar to those found in Third World countries today: a high incidence of infectious diseases (including tuberculosis, rarely found in southern Saskatchewan today), drug and alcohol abuse, a high birthrate and poor pre-natal practices, many single-parent families, lack of proper nutrition, and poor hygienic conditions for sewer and water.

Employment opportunities are few in the North, and for native people on the reserves and in the cities of Saskatchewan (Health of the Registered Indian Population, 1989). Native people have an average income much lower than that of other

Saskatchewan citizens. Many natives in the cities are among the users of the services of food banks and school and other feeding programs.

Another vulnerable group which requires special attention from the health care system is teenage mothers and their children. Saskatchewan had the highest rate of teenage births in Canada in 1989: 46 babies were born to every 1,000 girls aged 15 to 19 in 1988 (Vital Statistics, 1989 preliminary report, Saskatchewan Department of Health). Many of these young mothers lack information on how to cope with young children, and how to feed them nutritiously and keep them healthy.

People with physical limitations due to injury or disease make up only 14% of the Saskatchewan population (Statistics Canada, The Health and Activity Limitation Survey, 1986-87), but they have special needs and require special facilities if they are to live as normally as possible. In 1987-88, about 15% of the 19,000 people who used home care - a program primarily aimed at the elderly - were under 65. The numbers of young head injured people or those with paraplegic injuries have increased, and they need special support to help them live as much like their peers as possible. They have increasing expectations that society will help them to do so.

Consumer Expectations

During the public hearings it held throughout Saskatchewan, the Commission was impressed by the very high expectations people had for immediate, convenient, comprehensive and high-quality health care.

Medicare is often described as Canada's favorite social program, and this is particularly true in Saskatchewan, home of so many health care initiatives. Citizens of the province that gave birth to universal public health insurance, moved the mentally ill out of institutions and discovered cobalt therapy are informed about new developments in health care, and they expect to receive them close to home. The expectations of the health care system only grow; they never shrink.

However, while they expect more and take the comprehensive, universal and free nature of the medicare system pretty much for granted, Saskatchewan people are seldom enthusiastic about paying more taxes to provide for it. The special 10% lottery ticket tax the government introduced in 1989, with proceeds to go directly to health care, failed; lottery ticket sales plummeted.

There is a strong and perhaps unfounded faith that technology can fix almost any health problem. Many people waste the good health they were born with and then expect medical miracles to give it back.

It is important to note, however, there has been a striking change in this area. Over the last decade it has become apparent that more and more people are taking responsibility for their own health and demanding community responsibility as well. Personally, they are giving up smoking, improving their physical fitness and paying attention to their diets. In a community sense, they are demanding smoking controls and obeying seat belt laws. They recognize there are many environmental causes of illness and poor health, and are demanding that the environment be cleaned up and that laws against environmental pollution be strengthened and enforced.

These examples emphasize the unbreakable bond that links behavior and lifestyle and health. The more recognition there is of that bond, and acceptance of the personal and community responsibility it demands, the less will be the demands on the health care system.

And those demands have been tremendous. In 1989, when the provincial budget totalled $4.2 billion, one dollar out of every three was budgeted for health, $1.4 billion in all. If there are no changes, that figure is expected to surpass $2 billion by the turn of the century, and represent 36% of total provincial spending (Department of Health, 1989).

Changes in Patterns of Illness

The long-held dream that society would one day conquer illness has both come true and failed to come true.

Many illnesses have been conquered; for example, the World Health Organization has proclaimed the world free of smallpox. The truth about a disease such as leprosy, which once terrified people, has been revealed as far less frightening. Closer to home, the mass vaccination and inoculation of the population, combined with new drugs, has made death from infectious disease a rarity in most parts of Saskatchewan.

But the infectious diseases of yesterday have been replaced by chronic diseases with many causes which require extended treatment and care, such as cancer, stroke and heart disease. This trend is related to the aging of the province's population; the prevalence of cardiovascular, degenerative, malignant and other chronic diseases increases sharply with age. However, the increase in chronic disease also reflects general lifestyle practices, such as smoking and lack of exercise.

Since Saskatchewan has the largest proportion of citizens over 65 of any Canadian province, it is not surprising that health care use reflects that fact. Arthritis and rheumatism are widespread, and orthopedic surgery is in demand. More people have disabling problems of the circulatory system. There are more hearing and vision disorders; cataracts, for example, are more likely to occur among the elderly. Just over 46% of Saskatchewan seniors reported a long-term disability to Statistics Canada's Health and Activity Limitation Survey 1986-87.

Two key indicators of the health of a population are the infant death rate and life expectancy. Although the infant death rate in Saskatchewan declined significantly in the last 25 years - from 25 per 1,000 births to 8.4 in 1988 - it still ranked among the highest in Canada that year (Figure 4). Life expectancy, on the other hand, has increased nearly five years for women and over three years for men (Figure 5). This is not a dramatic increase over 25 years, but Saskatchewan women have one of the best life expectancies of women anywhere in the world.

Figure 4: INFANT MORTALITY RATES PER 1,000 LIVE BIRTHS BY PROVINCES, 1963 AND 1988

	1963	**1988**
Canada	26.3	7.2
Newfoundland	38.1	9.3
Prince Edward Island	21.4	7.1
Nova Scotia	27.0	6.5
New Brunswick	27.6	7.2
Quebec	30.0	6.5
Ontario	22.8	6.6
Manitoba	24.7	7.8
Saskatchewan	27.1	8.4
Alberta	23.6	8.3
British Columbia	23.5	8.4

Source: Infant Mortality, Dominion Bureau of Statistics, Cat. #84-524, 1950-84; Health Statistics Section, Health and Welfare Canada,March, 1990.

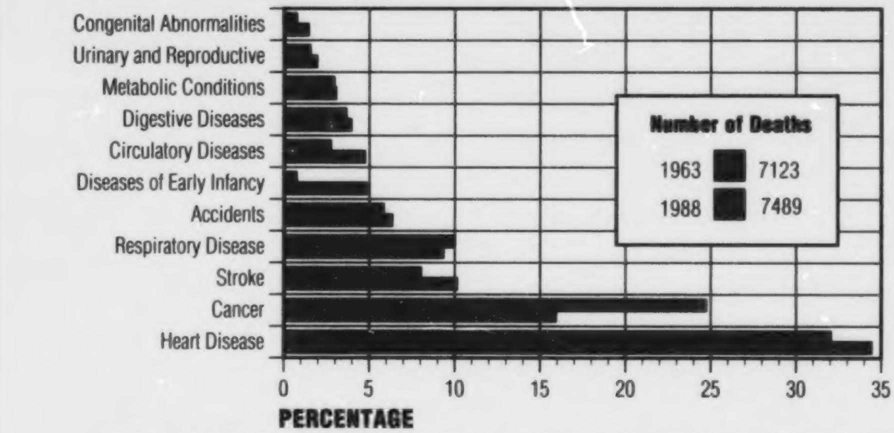
Figure 5: LIFE EXPECTANCY, SASKATCHEWAN 1941-1986

Age	1941	1961	1986
		MALE	
At Birth	65.43	70.27	73.66
Age 60	16.82	18.10	19.62
Age 80	5.76	6.31	7.59
		FEMALE	
At Birth	68.19	75.93	80.47
Age 60	18.26	21.09	24.21
Age 80	6.38	7.29	9.40

Source: Saskatchewan Vital Statistics: Annual Report 1987

Causes of death among the general population have not changed very much (Figure 6). In 1963, the most common causes were heart disease (34%), cancer (16%), strokes (10%), respiratory diseases (9%), accidents (6%), early infancy (5%) (Vital Statistics, Saskatchewan Department of Health, 1963). Nearly 30 years later, the most common causes were heart disease (32%), cancer (25%), respiratory diseases (10%), cerebrovascular diseases such as strokes (8%), accidents (6%). Accidents, especially traffic accidents, were the major causes of death for those under 45 in 1987; more than 40% of accidental deaths were alcohol-related (Health Status of the Population of Saskatchewan, Department of Community Health and Epidemiology, University of Saskatchewan, 1989).

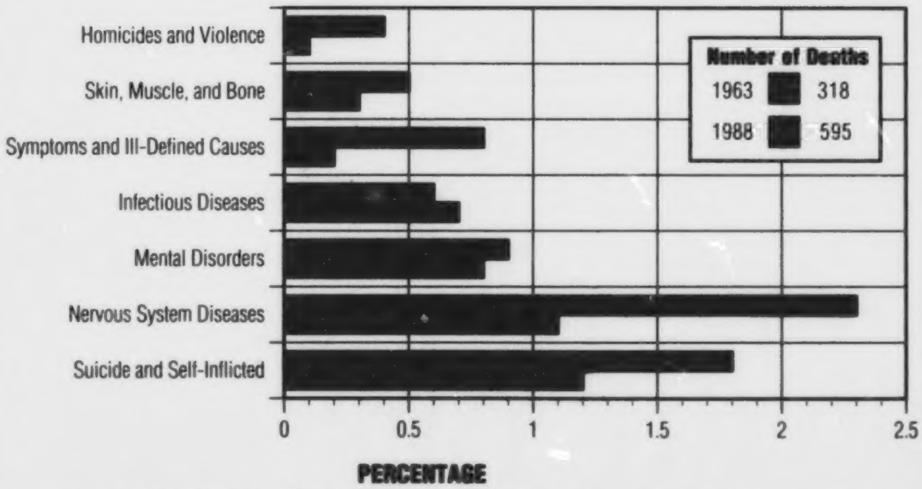
Figure 6: CAUSES OF DEATH, 1963 AND 1988



Source: Health Status of the Population of Saskatchewan, Department of Community Health and Epidemiology, University of Saskatchewan, 1989

	Population	Death Rate	Total Deaths All Causes
1963	939,466	8.0/1000	7441
1988	1,001,200	8.0/1000	8084

Figure 7: LESS FREQUENT CAUSES OF DEATH, 1963 AND 1988



Source: Health Status of the Population of Saskatchewan, Department of Community Health and Epidemiology, University of Saskatchewan, 1989.

The death rate from all types of cancer has increased from 126 per 100,000 population in 1963 to 197 per 100,000 in 1988 (Vital Statistics, Saskatchewan Department of Health, 1963, 1988). However, for some cancers, such as skin or cervix, earlier detection is more likely today to lead to a cure.

And although the actual numbers are small, the death rates from nervous system diseases, homicide and other kinds of violence, and suicide and self-inflicted injuries have risen strikingly (Figure 7).

Although the rate of AIDS within Saskatchewan is much lower than the national level, the disease still poses a serious health challenge. Up to March 26, 1990, 33 cases had been reported in the province, and 20 deaths (Provincial Laboratory, 1990). In Canada, there had been 3,604 cases and 2,169 deaths. The rate is rising and the number of cases in Canada is projected to double every 20 months.

It was very disturbing for the Commission to see the disparity in the health status of citizens of the North and the rest of the Saskatchewan population. Commissioners quickly recognized that health problems in the North require both health and social solutions.

Northerners have a shorter life expectancy, three to five years less on average than the figure for the province as a whole (Vital Statistics, Saskatchewan Department of Health, 1986). Health problems reflect social conditions in the North, such as unemployment. The incidence of family violence, suicide, alcohol and drug abuse is high. Northerners still suffer from tuberculosis, which has almost been wiped out in the south. There is a high incidence of sexually-transmitted diseases; the rate of gonorrhea, for example, is 1410% higher than for the province as a whole. Respiratory illnesses generally are more common, and children have far more ear problems.

Some health statistics for the native population in the entire province, including the North, illustrate the relationship between health and social conditions. Respiratory illnesses requiring hospitalization were more than six times as common among native children aged 1 to 4 in 1985 than among the entire population of that age. For ages 5 to 14, the hospitalization rate for injury and poisoning among native children was more than three times the rate among all children. The most common causes of death in 1986 for natives aged 45 to 64 were, like those of the general population, cancer and coronary heart disease; traffic accidents, diabetes and cirrhosis of the liver were other major causes, in that order. Among natives 25 to 44, the major causes of death were, in order, motor vehicle accidents, suicide and self-inflicted injury, homicide and intentional injury, other injuries, and pneumonia. Among the entire population of that age, the major causes were motor vehicle accidents, all other accidents, suicide, cancer and coronary heart disease (Saskatchewan Hospital Services Plan Annual Report, 1985-1986; The Health of the Registered Indian Population, 1986).

The infant death rate among natives is almost twice that for the general population, even though it has been brought down strikingly. At 15.4 per thousand live births in 1986, it was one-third the rate of 11 years earlier (Health Status of Saskatchewan Population, 1986).

Many of the health problems in the North directly reflect the fact that its water supplies and waste disposal systems do not meet the standard of the rest of the province. Many communities take their water untreated from a nearby river or lake, and few have any sort of waste disposal system. Another problem reflected directly in health care needs is the fact that foods essential to good nutrition are not available at reasonable prices.

Even the most brilliant futurist would find it difficult to predict specifically what will occur over the next 30 years in the health care field. If past performance is any guide, research breakthroughs will alter any projections - just as Jonas Salk's discovery of the vaccine that protected against the scourge of polio changed the projections of his time. Researchers may at any time find answers to AIDS or how to cure some of the 50 different kinds of cancer, outdating all projections for the needs of people suffering from those diseases. They will certainly continue to develop and fine-tune the physical equipment that is making diagnosis of many illnesses easier today.

We can't predict whether the illness and disability patterns of today will continue, or whether a new killer will appear on the scene with the suddenness of AIDS. However, it is possible to make some predictions that are soundly based on current realities.

Saskatchewan will have more and more elderly citizens who will need health care specifically directed to the particular physical problems that come with aging. The entire health care system must be gearing up for this emphasis. The College of Medicine must train more physicians and the nursing programs more nurses to specialize in such care, and hospitals must change to accommodate it.

The system must also recognize and adjust to what is already a *fait accompli*: more and more people receive their health care in urban, not rural, Saskatchewan. Urban hospitals must prepare for an increasing number of rural patients; this may require them to have hostels for people who need tests and day treatment, rather than put those people into costly acute care beds. Rural hospitals must accept this fact of life and adopt new roles; those roles will reflect the increasing proportion of rural people who are elderly.

The health care system of tomorrow will be enormously affected if people act to improve their personal lifestyles: change their eating habits to conform to Canada's Food Rules, set aside time in their lives for regular exercise, give up smoking and other habits that harm them, and generally take responsibility for their own healthiness.

Environmental factors will also affect the health care system. Efforts by society as a whole, led by government, to ensure a healthy environment - from safe water and clean air to controls on industrial emissions of all sorts to improvements in the workplace - will be directly reflected in the demands made on the health care system.

Finally, it is clear from the discouraging statistics cited earlier that unless society acts quickly to ensure that the people who live in Northern Saskatchewan have decent employment opportunities, housing and food and the same access to high-quality health care as their fellow citizens, they will continue to have higher infant mortality rates, shorter life expectancy, more susceptibility to infectious diseases, more violent deaths and other problems that are not acceptable in a society on the brink of a new century.

It requires no magic vision to predict that these are areas which must have specific attention if Saskatchewan is to remain a leader in health care in Canada, and ensure its million citizens the opportunity for both long and healthy lives.

Changes in Delivery Systems

Thirty years ago, Saskatchewan developed a health care system that met the needs of the province of that time, a province with its people spread widely across vast spaces in a network of small communities with cities much smaller than they are today.

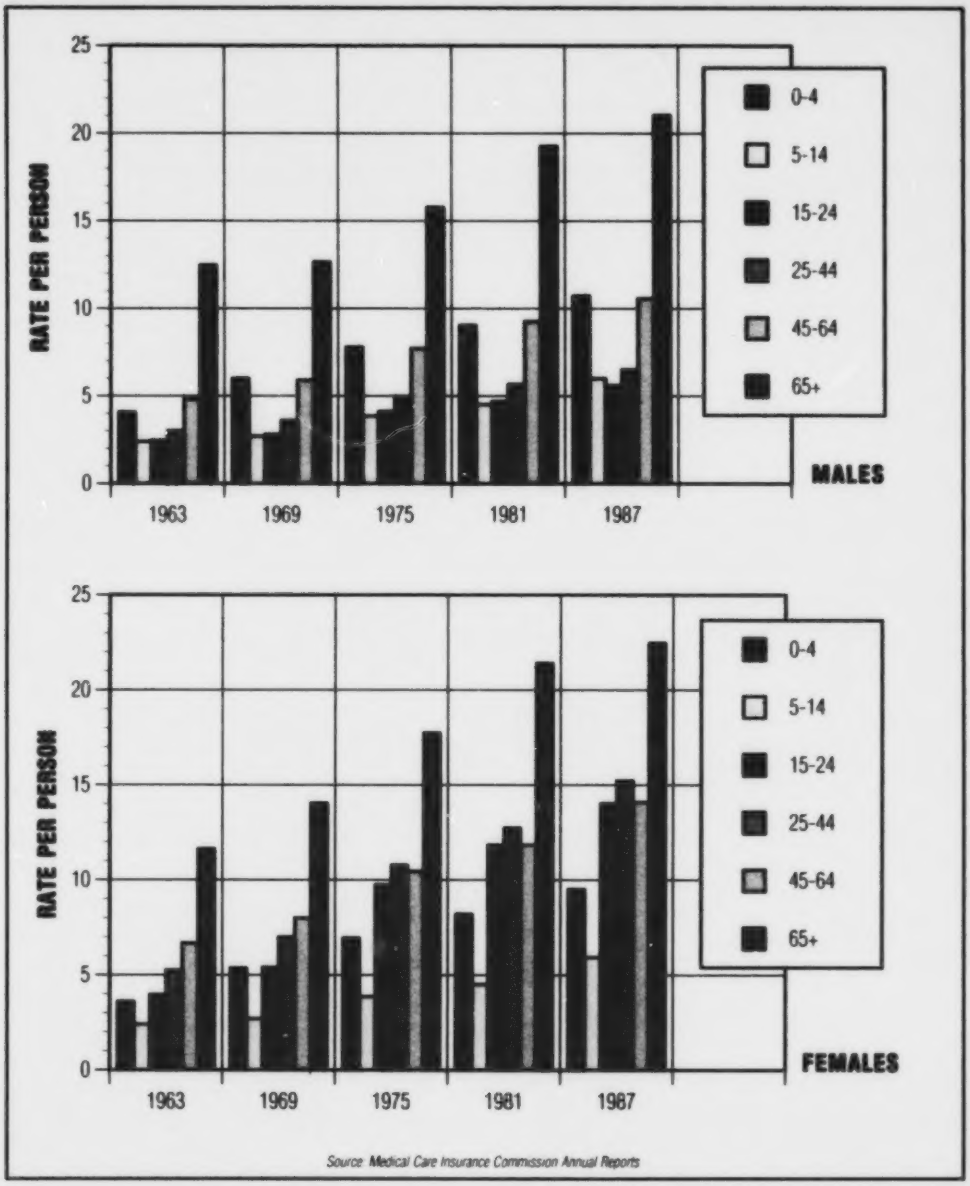
At that time, the province had approximately 725 physicians, divided between family physicians and specialists, almost two to one. The specialists were concentrated in Regina and Saskatoon, and smaller communities complained of shortages.

The numbers may be different, but this situation has not changed much over the years. As of February 1990, approximately 1,500 physicians were licensed to practise in the province, with about two-thirds being family practitioners and one-third specialists. The specialists recognized by the College of Physicians and Surgeons of Saskatchewan are overwhelmingly concentrated in Regina and Saskatoon; they are considered to be in short supply in both cities, and regional centres as well.

This year, 57 communities have one resident physician and 26 have two physicians (College of Physicians and Surgeons mailing list, 1990). Almost all of these physicians were trained in other countries .

Saskatchewan people make use of their physicians, too; in 1987, more than 85% of the people visited a physician. More people are going to the physician more frequently than they used to, and physicians suggest more return visits. Statistics show a clear correlation between physician numbers and their use, and the use of drugs and hospitals. Medical Care Insurance Branch data show that men and women of every age group used vastly more physician services per 1,000 residents in 1987 than they had in 1963. For example, women aged 25 to 44 used 15,224 physician services per 1,000 residents in 1987, almost three times the 1963 rate (Figure 8).

Figure 8: USE OF PHYSICIAN SERVICES, SASKATCHEWAN 1963-1987



Source: Medical Care Insurance Commission Annual Reports

Another trend of the late 1970s and 1980s was that more and more Saskatchewan people were bypassing their local hospitals to use those located in the larger cities. Occupancy rates of urban hospitals rose, while those in rural hospitals fell. On March 31, 1989, for example, 80% of the beds in the largest hospitals were occupied, as compared to only 62% of the beds in hospitals with fewer than 50 beds (Hospital

Services Branch, Saskatchewan Department of Health, March 31, 1989). This suggests that people may be bypassing their local physicians, as well.

Today, Saskatchewan has 134 hospitals, more than any province except Ontario (which has nearly seven times its population). Together those hospitals had 6.7 beds for every 1,000 people in the province, compared to the Canadian average of 5.1 per 1,000. Only six beds out of every 10 in rural hospitals with less than 20 beds are occupied each day, and frequently by patients who are not acutely ill.

But Saskatchewan puts people in hospital more than do other parts of Canada. In 1986-87, for example, Saskatchewan had 1,754 patient days for every 1,000 people, far more than the national average of 1,425 (Hospital Services Branch, Saskatchewan Department of Health). Age-sex differences between provinces do not account for this large a gap.

These patterns continue in institutionalization of the elderly. Like every other province, Saskatchewan has built quantities of long-term care beds since the 1960s. By 1989, it had 171 beds for every 1,000 people over 75, compared to 163 beds per 1,000 nationally. Only New Brunswick and Quebec came close to Saskatchewan's figure, with 183 and 172 beds per 1,000 respectively (Estimates based on the Directory of Long-Term Care Centres in Canada, 1988; Statistics Canada Population Projections for the Provinces, 1986). Fourteen per cent of all people over 75 were in long-term care institutions (Health Status of the Saskatchewan Population, 1989), but the Commission heard elderly people say over and over that they did not want to be institutionalized.

The statistics of the Saskatchewan Prescription Drug Plan are staggering. Figures indicate that its costs doubled every three years from 1981 until 1987 when the Plan was changed, while the number of prescriptions processed rose 6.1 per cent each year (Study into the Growth and Use of Health Services, 1989; SPDP preliminary data).

Particular stress was laid, during the Commission's hearings, on the over-medication of seniors; they, their organizations and physicians all spoke of it. And while it may not be literally true, comparing the number of seniors in the province and the number of prescriptions filled by people over 65 suggests that 17 prescriptions are sitting in the medicine cabinet of every senior in this province.

It was made clear to the Commission that some Saskatchewan consumers and their physicians are all too willing to take and prescribe drugs even in cases where prescriptions are unwarranted. In its brief to the Commission on January 26, 1989, the College of Physicians and Surgeons of Saskatchewan said:

> *"To our dismay, a high percentage of these (upper respiratory tract infection) patients come away with a prescription for an antibiotic without any real evidence of the presence of bacterial infection. When challenged to explain such prescribing patterns, many physicians indicate that they find themselves under considerable pres-*

> *sure from patients to prescribe antibiotics even though their professional training tells them that such prescriptions are of little value, may cause adverse drug reactions, and are wasteful of public resources..."*

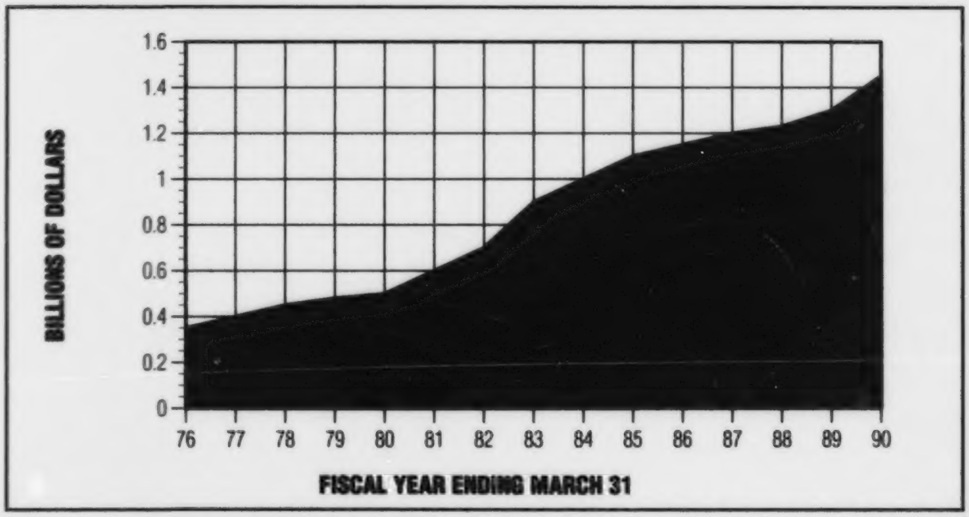
All these statistics make it very clear the Saskatchewan health care system is open-ended, constantly expanding, and lacking sufficient controls. New programs are added, but outdated ones are rarely subtracted, despite the lack of any evidence that they are achieving the goals somewhat vaguely laid out for them. There are no signs that this will change without deliberate action.

There are clear financial and social reasons for such action.

The formal health care system has grown enormously over the past 50 years, due in part to the tremendous advances in medical technology. The growth in our national and provincial wealth has enabled us to spend more on hospitals, nursing homes, drugs, doctors, chiropractors, dentists and related health products and services. And we have.

In 1989-90, the provincial government spent one-third of its budget on health care, almost $1,400 for each man, woman and child. Among Canadian provinces, only Alberta and Ontario spend more, although for those provinces health care constitutes only about one-quarter of their budgets (Health Data Interprovincial Comparisons, Saskatchewan Department of Health, 1989). Saskatchewan's health spending is escalating far faster than the rate of inflation (Figures 9 and 10).

Figure 9: SASKATCHEWAN HEALTH BUDGET, 1975-76 TO 1989-90



For one million people, $1.4 billion seems like a lot for health care, especially when one can reasonably ask if they are healthier or happier for it. That is unsettling, but what is far more unsettling is the fact that if the conditions of today continue unchecked, health care for one million people is going to demand more than $2 billion by the turn of the century.

Figure 10: HEALTH CARE SPENDING COMPARED TO TOTAL PROVINCIAL SPENDING

Fiscal Year	Health Spending	% Increase	% of Total Spending
1980-81	$ 650,900,000	14.8%	31.7%
1981-82	741,400,000	13.9%	30.7%
1982-83	880,100,000	18.7%	31.2%
1983-84	964,800,000	9.6%	32.3%
1984-85	1,027,300,000	6.5%	32.0%
1985-86	1,101,900,000	7.3%	30.4%
1986-87	1,236,115,000	12.2%	33.0%
1987-88	1,255,800,000	1.6%	32.7%
1988-89	1,284,400,000 *	2.3%	32.7%
1989-90	1,409,100,000 *	9.7%	32.7%

Figures are in current dollars and based on Saskatchewan Public Accounts, except for 1988-89 and 1989-90 figures, which are budget estimates. All figures have been adjusted to reflect programs, such as continuing care, transferred to or from other departments.*

Canada's provincial governments sponsored an international conference on Quality Assurance and Effectiveness in Health Care in 1989, at which speaker after speaker gave examples of the wasteful use of expensive health care resources. Much of the sickness care undertaken, they said, has no demonstrated value to those who receive it or only a very remote chance of providing marginal benefits.

In a personal brief to the Commission, one Saskatchewan doctor spoke about one aspect of this wasteful use of expensive health care resources. This doctor formerly worked at a minor emergency clinic:

> *"The most common health problem I saw at the MEC (minor emergency clinic) was that of the person who had a 'feeling of a cold coming on'. Often there were very few symptoms and the physical examination was negative. The majority, if they had symptoms, developed them the same day they came into the MEC. If these people had to wait a day or two or possibly drive a little further to see their own GP, I believe many would deal with it themselves as they have done in the past. Recent statistics show people in this province are going to physicians more often than ever before.*
>
> *"What concerns me most though is that many patients my colleagues and I see have been seen the same day or within 24 hours at a MEC for the same problem. The most common reason I hear is that they didn't trust the opinion of the examining doctor. A common example is that of a child with an ear infection seen at night at a MEC and given a prescription for antibiotics. The next day they present in my office, prescription in hand, wanting the ears checked again to see if the child really needs the medication.*
>
> *"These are not isolated events, but happen almost every day."*

In its attempt to improve the health of its people, Saskatchewan has built a system that is increasingly dependent upon technology, buildings and highly-trained professionals. People, the users of all these facilities and services, have become dependent upon them, and the system has encouraged them to do so. They want the quick fix with the newest treatment or technology they have read about or seen on television; only in the last decade have some made the kind of lifestyle choices that might keep them from needing such a fix. Few people are prepared to suffer even a little pain; medicine must cure it. Going to bed with a hot water bottle and an aspirin is no longer an appropriate response to minor ailments, people believe; they want the doctor to fix it. The system encourages and reinforces this attitude.

It is not idly that new technology is mentioned in this context, for that technology has some negative effects in addition to its overwhelming value to the health care system and the patient.

Used appropriately, new technology can alleviate severe injury and save lives. For example, developments in fibre optics and lasers have made it possible to perform vascular surgery to save limbs. Improved transportation and communication systems are making possible new ways to deliver care. It is possible, for example, for a modern jet to whisk a severely injured patient from La Ronge to Saskatoon in an hour. It is also possible for a radiologist in Saskatoon to read, by remote microwave hookup, an ultra-sound performed in La Ronge, and report back.

Diagnostic and therapeutic devices and procedures are becoming ever more complex. The very popular CT scanner costs over $1 million to buy and install and at least $250,000 a year to operate. Saskatchewan has six such scanners in its six base hospitals. New devices such as magnetic resonance imaging scanners ($2 million to $4 million each, depending on model) and lithotripters (about $2 million) are wanted, but how many of them does a province of one million people need and can it afford?

Canadian health economist Robert Evans estimates that technological advances combined with increased intensity in the use of these medical technologies accounted for over a third of health care cost increases over the last two decades.

Much of the current focus is on a handful of large, expensive and potentially dramatic aids for patients' diagnosis and treatment, like those mentioned above. However, the cost impact of medical technology may be related to the adoption of thousands of new tests and procedures which individually cost very little but which add up to even greater dollar amounts.

For example, laboratory services for Saskatchewan's one million people more than tripled in cost over the decade from 1977 to 1987. Three reasons are given for this increase: tests were more expensive, each person had more tests, and more people received tests (Study into the Growth and Use of Health Services, 1989).

For 40 years, Saskatchewan has been a leader in health care services in this nation. In that time, the system has become steadily more sophisticated, more expert, more technological, and larger. Where once there were specialties, now there are sub-specialties. Where once physicians acknowledged they could do no more, now there are varieties of treatments to be aggressively tried. It is alleged that because they fear accusations and lawsuits, they use every possible test and procedure. Great resources are expended on people in the last 12 months of their life, usually to no avail. Death is not seen as the inevitable outcome of some conditions, a natural part of life which is sometimes even welcomed; it is always the enemy.

The health care system is complex and troubled in this time of change and transition. Let us quickly summarize those changes that affect it:

- urban-rural split in population, more elderly in rural areas
- more rural residents turn to health care in urban areas
- the elderly proportion of the population is increasing; the young decreasing
- in the North, small communities thrive, with a preponderance of young people
- families are smaller, mobile, less stable, and have two adults in the workforce
- there are more poor, including many elderly who live alone and families and children in the large cities
- Northern Saskatchewan has health problems that are unique and reflect social problems such as unemployment
- Saskatchewan has Canada's highest rate of teen pregnancy
- faith in and demand for medical miracles and technology
- vast amounts spent on health
- change in illness patterns
- new emphasis on fitness and health
- too many rural hospital beds, too few community-based services
- too little attention to the environment
- problems of distribution of health professionals
- growth in use of physicians, hospitals, nursing homes, drugs
- failure to measure outcomes of treatments

This abbreviated list is the shorthand for a health care system that must be revamped to match it to the needs and situations of today and tomorrow. It is not yet in crisis and it works relatively well for most people, most of the time, but new directions and new approaches are desperately needed. The Commission has concluded that it cannot continue in its present style or return to the style of years gone by, even if there were unlimited quantities of money. It must evolve in an entirely new direction to respond to new challenges, new opportunities, new ways of thinking.

Why does Saskatchewan need a new health care system? The Commission believes this first section answers that question clearly and succinctly. What should be the principles of that new system? The next section spells those out one by one. The succeeding sections describe and detail a new system that builds proudly on the glories of the past, responds boldly to the needs of this province in the 1990s and the 21st century, promises to be effective and adaptable and, above all, sensitive to people, and will make Saskatchewan again a leader in health care in this nation.

2. Principles for Change

The Saskatchewan health care system was described in one major brief presented to the Commission as resembling a house built years ago for a small family. As the family grew and its financial position improved, changes were made and additions tacked on here and there. New equipment was added, new building materials used, and the house took on a new appearance several times. It did the job of housing the family, although it remained haphazard and operated with inefficiencies to which the owners became accustomed and perhaps even partial.

The Commission was charged with the responsibility of redesigning the health care system built in Saskatchewan in the 1940s for the province of the 1940s, and enlarged upon in the 1960s for the province of that time. Both were state-of-the-art for their eras but, as the previous chapter demonstrates, the need for change is clear.

The health care system born and nurtured in Saskatchewan has been enshrined nationally in The Canada Health Act. The Commission supports the principles of that Act, and has founded its redesigned system on them and on the health care ideals that Saskatchewan people determined long ago and still hold dear today: universality, comprehensiveness, accessibility, public administration, quality, freedom of choice and responsibility.

Universality ensures that everyone has an equal opportunity to receive health services and the most effective treatment, regardless of their economic and social needs and circumstances.

Comprehensiveness promises that a full range of essential health services is provided to Saskatchewan citizens, as has traditionally been done.

Today, **accessibility** means that each citizen is able to receive quality care appropriate to his or her legitimate needs with a minimum of inconvenience.

Public administration means that health care programs and services should be the responsibility of public authorities at the federal, provincial and local levels and should be administered and operated on a non-profit basis.

Quality means that health care services are provided in keeping with the advances made in professional training, expertise and technology, and in a sensitive and caring way. It does not mean quantity.

Freedom of choice means that within appropriate limits, a consumer has the right to seek out health care in a way that does not limit him or her to a prescribed place or kind of treatment.

Responsibility means that all citizens practise lifestyles which contribute to their own health and that of others and work jointly for a clean environment, and that both consumers and health care practitioners are responsible in their use and provision of services, respectively.

The Commission accepts those same principles as vital to the new health care system for the 1990s and 21st century. However, after it listened to the briefs presented to it across the province, it was convinced these principles must be expanded, taking into account the projections for the future and the successes and problems of the present system. The new health care system must stand on the twin bases of principles that have been proven over the long term and new ones that respond directly to the situations of today and tomorrow.

Sense of Ownership

The health care system must be owned by the people it serves; this is the first and most vital principle. Throughout its public meetings and in many of the briefs it received, the Commission was told of the need for local ownership of the system. That means it must be decentralized, giving local people influence and authority over it, control of it, and responsibility and accountability for it.

A Provincial System

In terms of its objectives, the services it provides and the standards it ensures, the health care system of Saskatchewan must have a provincial dimension and direction. A distinctly Saskatchewan system with a unique character, it acts as a unifying force among the locally-controlled regions.

Focus on Health

Health care must focus more on health and less on sickness. A true health care system for the 1990s and beyond will emphasize personal and community responsibility for health, health promotion and care of the environment, with a wide range of efforts aimed at disease prevention, and quality care in time of sickness.

Continuity of Care

Tomorrow's health system must be unified, with unbreakable links among its various facets. No longer can it be chopped into acute and long-term institutional care, home care, community services, mental health services. A unified system will provide people with the services they need and ensure there are no cracks for them to fall between.

Quality of Life

The system must provide for more independence for health care consumers and aim at reducing dependence on institutional care and professional services. It must start from the belief that people, when they become sick, disabled or old, will be encouraged to live privately and independently for as long as possible, supported by community services as needed.

Professional Teamwork

Professional services must be delivered through interdisciplinary teams whose members share responsibility and authority, who work interdependently and co-operatively, and whose roles complement each other.

Effectiveness

This old principle takes on a new meaning: the health care system must be outcomes-oriented. The crucial question must always be, what will be the outcome for the person of this treatment, this medicine, this therapy?

Adaptability

The health care system must be flexible and able to adapt to changing times and circumstances in a huge and varied province. This very diversity must be seen as an opportunity to develop new ways of improving health and delivering services, to explore options and alternatives.

Affordability

Ensuring a health care system is affordable means making it streamlined, efficient and effective, reducing open-endedness and abuses, and relating it to provincial resources. It does not mean lower quality or less adaptability and innovation, but it does mean the subtraction of programs and services which do not achieve their goals.

Consultation

Those who manage the health care system, at every level, must consult with their local communities, consumer groups, and with health care professionals. Such consultation can be time-consuming, but it helps to ensure the rightness of the choices and the commitment of the entire community to those choices.

• • •

These principles, which reflect the realities of the province and the needs, desires and ways of its people, are the blueprint for the Commission's vision of a health care system that will serve Saskatchewan through this decade and into the 21st century. What follows, to continue the construction metaphor, are the building specifications. The principles spell out where the province must go; what follows shows how to get there.

This new system, the Commission believes, will serve Saskatchewan people in a way that is not only better, more effective and more humane, but gives them more for their money. It also demands more of them. There is no question they can meet those demands, once they are convinced this is their health care system, and it will help them help themselves to health.

B. DIRECTIONS FOR CHANGE

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1. A Consumer-Controlled Health Care System

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Foreword

After agreeing on the principles for the health care system of the 1990s and beyond, the Commission used them to build the new system it envisioned.

It quickly became clear that the overriding principle - that the people it serves must have an increased sense of ownership and control of the health care system - could only be achieved through a new kind of structure. Evidence of a degree of such ownership and control exist, through a bewildering array of boards, institutions and agencies with different geographic and service jurisdictions. Those boards have approximately 3,500 members; most of them are appointed and many are not known or accountable to the people who use the facilities.

The Commission is convinced that the very numbers of boards and institutions interfere with local ownership and control, confuse people seeking service, and defeat the vital concept of oneness. That most of these boards are appointed and not directly accountable exacerbates the problem.

Old habits will prevail, the Commission believes, if all these boards, agencies and institutions continue to line up separately for provincial funding. Institutions will be financed first, and best. Community-based services will get less, though they best live up to the principle that the ill and the old should have more independence at home, rather than dependence in an institution. The mental health services on which Saskatchewan once prided itself will be perpetually stuck at the back of the funding line.

The Commission found that some communities have already recognized the health care system must be streamlined before it permanently bogs down. It was encouraged by the efforts of the District Co-ordinating Committees, though it believes that such voluntary approaches are mainly efforts to oil the cogs of a huge and cumbersome machine.

The answer to these needs and solution to these problems lies in creating a regional system for the delivery of health care, the Commission concluded. This conviction was reinforced by the discovery that the same conclusion has been reached in other provinces which have recently examined their health care systems; New Brunswick, Nova Scotia, Quebec and, closer to home, Alberta. However, this report contains proposals different from those recommended elsewhere, and the Commission believes they will best suit Saskatchewan.

Only a regional health care system can empower local people and create a strong and unified system, with equal emphasis on all services, and make it easier for people to find out what services are available and get quick access to those they need, the Commission believes. The funding should still be mainly provincial, but elected local people must have more say in what is offered and funded.

There is a new challenge, too, in the way that funding is allocated among the various health care services, a challenge directly related to the principle of local ownership of the system. The local people who run the system must determine needs and match resources to them in a sensitive and responsive way, and have the flexibility to change the emphasis when needed. This is not mere budgeting; this is resource allocation.

The Commission recognizes that health care needs are likely to vary from region to region, and believes the system must permit those variations to be recognized. This will mean that health care services may differ among the divisions. It sees no problem with that difference, provided a common base of service is offered everywhere.

It is in this latter regard, the Commission believes, that the government has a particular responsibility. In a province as vast and sparsely populated as Saskatchewan, the Department of Health must be involved to ensure quality and equality of basic care. It must play a leading role in shifting priorities from sickness care to health care, another of the overriding principles behind this report. And it must make sure that all services are evaluated in terms of their outcomes.

The final argument for regional health care is so simple that it is easily overlooked. The idea of community has already changed in Saskatchewan, with highways that bring places closer and closer together. It is striking how many people in rural areas and small communities set off down those highways now to get health care services in the cities and some regional centres. The Commission believes this illustrates the truth that health care 'communities' can stretch across many miles and still be local. Such larger communities will more easily attract the teams of health professionals that are a must, in its view.

What follows are specific recommendations for the organization, delivery and funding of this province's health services. This is the most important section of the Commission's report, for it opens the door to new and exciting opportunities that can make Saskatchewan's health care system once more a model for Canada. From this section flows all the rest of the report.

Geographic Divisions

The Commission believes that dividing Saskatchewan into geographic regions with straightforward common boundaries is the best way to deliver health care and ensure local control of that delivery.

Many factors led it to that conclusion.

With more than 400 boards responsible for hospitals, long-term care centres, ambulances and home care, and with each board operating in a different geographic area, the health care system is made enormously complex, and co-ordination and continuity of care become enormously difficult.

Because many people have moved from rural to urban areas and because the population mix has changed, with more elderly people, especially in rural Saskatchewan, health care services must be delivered in a different way. There is a growing acceptance of the need for different relationships and partnerships involving health care institutions and community programs.

Today, Saskatchewan people recognize their community has become broader, that a community here can include larger and smaller centres within one whole. They realize more and more that viability may be increased by interdependence and reliance among several communities within an area, and that where they go for business and services has changed significantly.

For all these reasons, the Commission is convinced that health services must be delivered through geographic areas. In proposing this, it took into account that certain regional identifications exist, fostered by such factors as trading patterns, mass communication links, and athletic and recreational activities. For purposes of delivering health services, these also appeared to be important factors in defining division boundaries.

RECOMMENDATIONS

1.1 The province should be divided into 15 comprehensive HEALTH SERVICES DIVISIONS for the purpose of organizing and delivering health care services and which will result in a system characterized by integration of services and continuity of care.

(a) The divisions should be determined in this way:

(i) Ten rural divisions to deliver services to their residents.
(ii) Two large urban divisions to deliver services to residents of Regina and Saskatoon plus certain selected services for the entire province.
(iii) Three northern divisions with programs uniquely designed to serve the needs of northern residents. (Refer to Section 6).

1.2 The 10 rural divisions should be set up on the basis of such factors as existing health care resources, geographic features, travelling patterns for services, and cultural and historical relationships.

(a) Their populations should range between 40,000 and 80,000.

(b) Their boundaries should be drawn along existing rural municipality boundaries to avoid splitting R.M.s between divisions. The Commission suggests boundaries as shown on a map at the end of this section.

(c) Within each division, five or six electoral subdivisions should be established, depending upon population and geographic considerations.

1.3 Two large urban divisions should be established for Saskatoon and Regina, responsible for providing basic health care services for their residents as well as more specialized types of care (involving advanced technology and highly specialized training) to the population of the whole province.

(a) The two urban divisions should have boundaries corresponding to the officially designated limits of each city.

(b) Residents of the two rural divisions immediately adjacent to Regina and Saskatoon should continue to receive health services in the respective cities, on the basis of contracts between the urban and rural divisions.

Health Services Division Councils

During its public hearings, the Commission repeatedly heard concerns about the way the health care system is managed, and the desirability of transferring some of the responsibility for its management from the provincial government to local authorities.

Many reasons were given for these positions.

Over and over, people referred to the way in which health care has been fragmented and divided into compartments, making it more complex and making people uncertain about who has responsibility for various programs.

The Commission was told repeatedly that the system has been highly politicized over the decades, so that priorities and directions for the health of Saskatchewan people were often determined by the possibility of political gain. Because of this, honest suggestions for change often bring charges that those who make them are trying to dismantle the system. The fact is more and more people realize that a different way to make changes is needed.

Finally, many people expressed to the Commission their concern that individual residents of Saskatchewan feel no sense of ownership for the health care system. They called for changes which would give individuals that sense of ownership, and thus influence the demands they make and the outcomes they expect.

The Commission was impressed with these arguments and believes that changes must be made to give increased control of the health care system to the people it serves, thus encouraging that sense of ownership.

RECOMMENDATIONS

1.4 A health care authority known as the HEALTH SERVICES DIVISION COUNCIL must be established within each of the 12 divisions in rural and urban Saskatchewan to manage the health care programs within its mandate.

(a) The division council for a rural division should consist of 10 to 12 members elected for a three-year term by its residents, on the basis of two councillors from each subdivision.

(b) The large urban divisions (Saskatoon and Regina) should be represented by a total of 12 members, including two representatives from the rural divisions and, on the Saskatoon council, one representative from the three northern division councils, with the remaining members being elected at large within each city.

1.5 Each rural and urban division council should be chaired by an elected councillor selected by his/her colleagues at an annual organizational meeting.

(a) The chairperson should be appointed for a one-year term with eligibility for re-appointment without a limit on the number of terms.

Mandate of Division Councils

Both providers and consumers of health care told the Commission repeatedly that health care services must be better co-ordinated to get rid of the compartmentalization that exists today because so many different boards are responsible for so many different programs.

Several provincial organizations suggested specifically that much more co-ordination and co-operation are needed among the different agencies in the health care field. Provincial seniors' organizations believe that services should complement each other; other groups, too, expressed commitment to the concept of a continuum of lifelong care.

It was drawn to the Commission's attention that some services, especially those that are community-based, exclude some people. For example, home support services may not be available to a mentally ill or multiply handicapped person in the same way they are to some less dependent people.

These factors, and the improvement in technology, especially in communications, convinced the Commission that to ensure the most effective and efficient use of the resources devoted to health in Saskatchewan, services must be delivered in a co-ordinated way. That conviction influenced the Commission's recommendations on the duties and responsibilities of division councils.

RECOMMENDATIONS

1.6 Division councils must have the authority and responsibility for all aspects of health care, including program planning, evaluation, budget allocation and management, and arrangements to deliver acute care, ambulance services, long-term care, community-based services and mental health.

(a) The programs to be included within the division councils' mandate should be designated by the government through the Department of Health.

(b) The councils would also be responsible for:

  (i) accountability to their residents, and to the Minister of Health, for financial management and program delivery within the division.
  (ii) accountability to the Department of Health for the appropriate use of public funds allocated for the provision of adequate health care services within the division.

(c) The division councils would employ all senior management, institutional management, professional, supervisory and health care delivery staff.

(d) The councils would become the owners of all publicly-owned health care facilities within their boundaries.

(e) The councils would continue to respect the private nature and ownership of hospitals and long-term care centres operated by religious communities, church organizations or health care corporations, and make contracts with them to provide services to the division.

1.7 In addition to their normal responsibilities to their own residents, the division councils of Regina and Saskatoon should also be responsible for more highly specialized hospital care and generally for the highly sophisticated services which are to be provided to residents throughout the province.

(a) Certain highly specialized services for the total population should be available in both divisions.

(b) The most specialized services should be rationalized, with some available in Regina and others in Saskatoon.

Administrative Structures for the Divisions

Briefs to the Commission from different agencies suggested the need for far more co-ordination and, indeed, amalgamation of services at the local level. More liaison between boards and administrations of various health care institutions was also urged.

The increasing importance of better co-ordination was frequently reflected in the support expressed for the work being done by District Co-ordinating Committees, which evaluate people's need for health services and co-ordinate the delivery of services by hospitals, home care and long-term care centres.

Examples of local initiatives taken to increase co-ordination and amalgamation which were presented to the Commission include the establishment of planning committees with representation from different institutions, which, in some communities, has led to the employment of a single administrator for a group of facilities.

Under these circumstances, it is evident that with the establishment of division councils, an administrative team model must be developed which will ensure a more holistic approach to the delivery of health care services.

RECOMMENDATIONS

1.8 Each division council must establish a management structure which enables its mandate to be carried out in the most effective and efficient way, with the highest degree of financial accountability, and which ensures that a comprehensive range of services is delivered in a manner consistent with the principles underlying quality care.

(a) The management staff should consist of a chief executive officer with a direct reporting relationship to the council and responsibility for ensuring that a team of professional and administrative staff is available to serve at the various levels of the system.

(b) To advise it on the major programs, each division council should appoint standing committees, chaired by division councillors and comprised of representatives of the division council, health care professionals and consumers.

Budgeting and Funding Systems

The Commission heard a variety of concerns about the existing system of funding health care in the province. It was suggested that the complexity and comprehensiveness of health care programs have increased and expanded but the funding mechanisms have not changed sufficiently to reflect new circumstances.

The concern was not so much about the adequacy of funding. Rather, it was about factors such as :

- the lack of a systematic basis for determining directions and priorities for health care programs.
- the inconsistencies in the rules which determine operating and capital budgets, particularly in the institutional care area.
- the lack of incentives in the budget formula, which prompts a "spend all we've got or it will be taken away on us" attitude.
- the increased influence of political pressure in determining the allocation of funds.
- the lack of measures to determine the effective use of public funds, particularly an insufficient focus on results and outcomes.

These concerns, as well as the increasing appreciation of the fact that the system must be updated, suggested that an in-depth review of the way health care is financed was appropriate.

Finally, the funding policy must be restructured to accommodate the Commission's recommendations for the establishment of division councils responsible for delivering a comprehensive package of health services. The financial policies of the future must enhance the ability of these councils to make decisions about priorities and programs within their divisions. In other words, the funding formula must ensure that a core program of health services is available but not be prescriptive about how funds are allocated.

The Commission is convinced that, with the development of computer systems and improved management skills, it is possible to develop a funding system which will contribute to a more effective use of resources.

RECOMMENDATIONS

1.9 Division councils must have authority and responsibility for the financial management of health care programs and services assigned to them and must determine operating plans and priorities, allocate resources and distribute funds in accordance with their own budgets.

(a) The major source of funding must be the Department of Health and the allocation to each division must be determined on the basis of uniform provincial guidelines and recognition of any needs and circumstances peculiar to a division.

(b) Provincial funds must be allocated to each division on a global basis and each division council must be responsible for determining its priorities for allocating funds to different programs and services, reflecting the special needs and directions of the division.

(c) The budget of each division council must be determined on a per-capita basis, taking into account the total population, age and sex distributions, epidemiological considerations, socio-economic status, and the required scope of services provided by the council.

1.10 Each division council's budget must reflect and incorporate a commitment to quality health care according to provincial principles and standards, but also recognize the need for long-term planning, and for reflecting special circumstances or needs within the division.

(a) Each division council must submit to the Department of Health a three-year plan which identifies budgetary plans and priorities for various purposes. The Department should make its funding allocations on a yearly basis related to the three-year plan, with annual adjustments as determined by changing circumstances.

1.11 Division councils' financial policies must be founded on principles which reflect outcomes measurement, operational incentives and management accountability.

(a) Division councils must ensure that adequate monitoring of financing takes place so that if difficulties exist, they can be discovered early and action taken through consultation with the Department of Health to correct them.

(b) The Department of Health must have legislation which would permit the Minister of Health to appoint a public trustee for a division council which has been unable to manage its budget effectively and produces serious financial difficulty for the division.

1.12 Division councils should be permitted to retain any surpluses at the end of a fiscal year and use them in accordance with uniformly-established guidelines developed by the Department of Health in consultation with division councils.

Sources of Funding

While it calls on Saskatchewan people to take more responsibility for the operation of their health care system, and recommends more local authority and autonomy, the Commission stresses that health must remain a provincial system in terms of quality, accessibility, equitability and affordability. Its recommendations are intended to ensure that all division councils meet these basic principles.

The Commission heard many briefs which said that funding health care must remain a provincial responsibility.

Some briefs expressed concern about legislation and policies on funding which apply differently to different institutions. For example, among all health care institutions, local property taxes are levied only for hospitals, and even at that, there is a wide variation in the local contribution. In 1987, the municipal levy for hospitals ranged from zero to 27.6 mills.

The Commission's attention was drawn to the increase in fund-raising activity by health care institutions in the province. Many hospitals and long-term care centres have formed charitable foundations, a situation that seems to confuse and bewilder the public. People question the need for this extensive activity since most facilities are publicly owned, and have expressed concern about the competition for the charitable dollar. The Commission has become aware of the fact that sophisticated fund-raising schemes of large institutions in our society enter into pronounced competition for charitable dollars which were once directed to smaller and less sophisticated health and social agencies.

In their search for supplementary funds, health care institutions have become involved in retail-type activities such as outlets for patient amenities, flower and gift shops, staff cafeterias and parking lots. Such initiatives can produce revenue for health facilities without jeopardizing patient access to essential care and sometimes even enhancing care by offering conveniences which would not otherwise be available.

RECOMMENDATIONS

1.13 To ensure adequate funding for an integrated and comprehensive health care program, legislation and policies must be developed by the provincial government as well as by division councils which define the basis on which division councils will obtain funds and decide on their allocation.

(a) Provincial legislation must identify the total spectrum of health programs and activities which division councils will be responsible for delivering and which will be funded by the Department of Health.

(b) The legislation should permit division councils to raise funds through a municipal levy for special program initiatives or for any special needs that help them maintain a sound budgetary position. Revenues raised through such a levy should not exceed 5% of the provincial allocation.

(c) Legislation should give councils the authority to undertake fund-raising for supplementary projects and initiatives beyond the basic health care services, with the approval of the Department of Health.

(d) Division councils should permit institutions to establish retail-type revenue-producing operations which provide a benefit or convenience to patients, friends, families and staff, but which do not require program funds to keep them viable.

Financing of Construction and Capital Equipment

Several briefs presented to the Commission expressed concern about existing policies for funding construction projects, furnishings and equipment. It was pointed out that inequities exist between one type of facility and another in the amount of funding required from local sources. Because of the variations in assessment, this frequently results in inequities in the amounts contributed by different communities.

Presenters also raised questions about the appropriateness of policies which require larger acute care facilities to raise funds for highly-sophisticated and costly modern medical technology. There were further concerns about the competition that has arisen among the major hospitals for funds from individuals, as well as businesses and corporations. The Commission recognizes the need for a new system of funding, one which considers the need and the mandate of the institution concerned.

RECOMMENDATIONS

1.14 Each division council must develop a five-year capital plan for construction, furnishings and equipment required for acute care, long-term care, mental health, ambulance units and other facilities, including those which are privately owned.

(a) The long-range capital plan must be submitted to the Department of Health for its consideration and approval, resulting in the division's capital program strategy for a specified five-year period.

1.15 The provincial share of funding for construction of a new institution, expansion of an existing facility and the initial equipment and furnishings for such facilities will be determined by their category and mandate.

(a) The provincial share of construction funding will be 95% of approved cost for base hospitals.

(b) The provincial share of construction funding for all other facilities will be 80% of approved costs.

(c) The provincial share of equipment and furnishings for all new construction will be 100% of approved costs.

1.16 Each division council must establish a capital reserve fund for replacing furniture and equipment and renovating facilities, and must receive an annual capitation grant calculated by the Department of Health for the purpose of maintaining the fund at a level appropriate to the facilities under the council's jurisdiction.

(a) Replacements and improvements must be funded equally by a division council and the Department of Health, each paying 50% of approved costs.

Division Council Co-ordinating Board

Division councils will have authority and responsibility for the health care programs within their divisions. However, there will be many instances in which inter-divisional relationships must be defined and policies developed for co-operation and support.

There is a pressing need for a mechanism for inter-divisional consultation, communication and co-ordination of institutional services. Certain formal linkages will have to exist, particularly involving the two large urban divisions and the rural and northern divisions.

As well, a number of provincial agencies will continue to have responsibility for delivering services directly. To ensure those services meet the needs of the various parts of the province, a formal liaison is needed between the agencies and the councils. A formal relationship must also be established between the councils and the Health Analysis and Development Commission. (Refer to Section 5).

RECOMMENDATIONS

1.17 A DIVISION COUNCIL CO-ORDINATING BOARD must be established, consisting of the chairpersons of the 15 division councils, to facilitate communication, liaison and co-operation among the divisions and with the Department of Health, provincial agencies, and the Health Analysis and Development Commission. (See Section 5).

(a) The board should select division council representatives to various provincial boards such as the Saskatchewan Cancer Foundation.

(b) The board should develop policies and practices for the inter-divisional delivery of health services, providing formal linkages between institutions wherever appropriate.

(c) The board should have a formal reporting relationship with the Health Analysis and Development Commission so it can co-operate in the provision of information and receive analysis based on research undertaken by the Commission.

(d) The board should develop strategies for liaison with various agencies associated with the health care field, including educational institutions, Department of Health branches, and advisory groups.

(e) The board should meet regularly as determined by its agenda, but not less than twice a year.

Role of the Department of Health

The restructuring of the health system, and particularly the transfer of significant responsibility and authority to division councils, will have a major impact on the role of the Department of Health.

The Department will continue its monitoring and regulatory role to ensure that high-quality standards are established and maintained. Furthermore, it will continue to manage the government's health budget, and ensure the appropriate allocation and spending of provincial funds.

The Department currently has a major responsibility in the direct delivery of a variety of health services, particularly in the community and mental health fields. While it will continue to directly deliver a limited number of programs, its role as a health care provider will diminish significantly as division councils assume responsiblity for most programs.

Perhaps the most important change in role for the Department will be in the leadership and support it provides to the division councils. The health of Saskatchewan residents is now and should always continue to be a social responsibility; the government, and specifically the Department of Health as its agent, must ensure the province's health needs are met.

It will be the Department's responsibility to ensure the new system continues to provide high-quality and accessible basic health services to all Saskatchewan residents. The success of a decentralized and locally-administered health system will be determined to a significant degree by the Department's commitment to providing the necessary leadership and support in its transition and ongoing management.

Initially, the Department must ensure that adequate and appropriate resources are available to enable changes in the health system to take place. Then it must work closely with Saskatchewan communities to establish the necessary structures, processes and resources which will enable the division councils and their communities to assume the responsibility for health delivery.

As the division councils develop their independence and capability to administer and manage their programs, the Department's role will evolve to one of providing strong leadership in the planning, development, management and evaluation of programs to meet the ever-changing needs of Saskatchewan's population. The Department will have to focus its efforts on providing a vision for health care in this province, establishing priorities and leading the division councils in the directions demanded by a changing society.

RECOMMENDATIONS

1.18 To implement the divisional system for managing and delivering health care services, a special transition unit should be established in the Department of Health with the status of a branch, reporting directly to the Deputy Minister and containing expertise on organizational development, strategic planning, resource allocation, legislation, funding and administration.

(a) The transition unit should propose to the Department of Justice drafts of the necessary legislation to establish the proposed divisions and assign responsibilities to the division councils.

(b) The transition unit should identify for the Department of Justice the various acts pertaining to institutions, community-based programs and health professionals which may need revision as a result of the establishment of division councils.

(c) The transition unit should provide the resources to set up the initial council in each division, and help it establish its administrative organization.

(d) The transition unit should develop training and orientation programs for newly-elected councillors and their management staff.

1.19 The Department of Health must be instrumental in developing policies to ensure that employees who now work for a variety of agencies retain their benefits and levels of compensation to the greatest degree possible when they become employees of the division councils.

1.20 The Department of Health should provide ongoing leadership by establishing the principles of health care delivery in the province; by planning, evaluating and priorizing health programs at the provincial level; by serving as an advocate within government for public policy and funding support for health; and by providing administrative and program consultation and support to the division councils.

1.21 The Department of Health should continue to have direct responsibility for certain programs and services which are more appropriately considered in the total provincial context than as part of the division program.

(a) The Department should directly deliver such programs as the Saskatchewan Hearing Aid Plan, the Provincial Laboratory, and Vital Statistics.

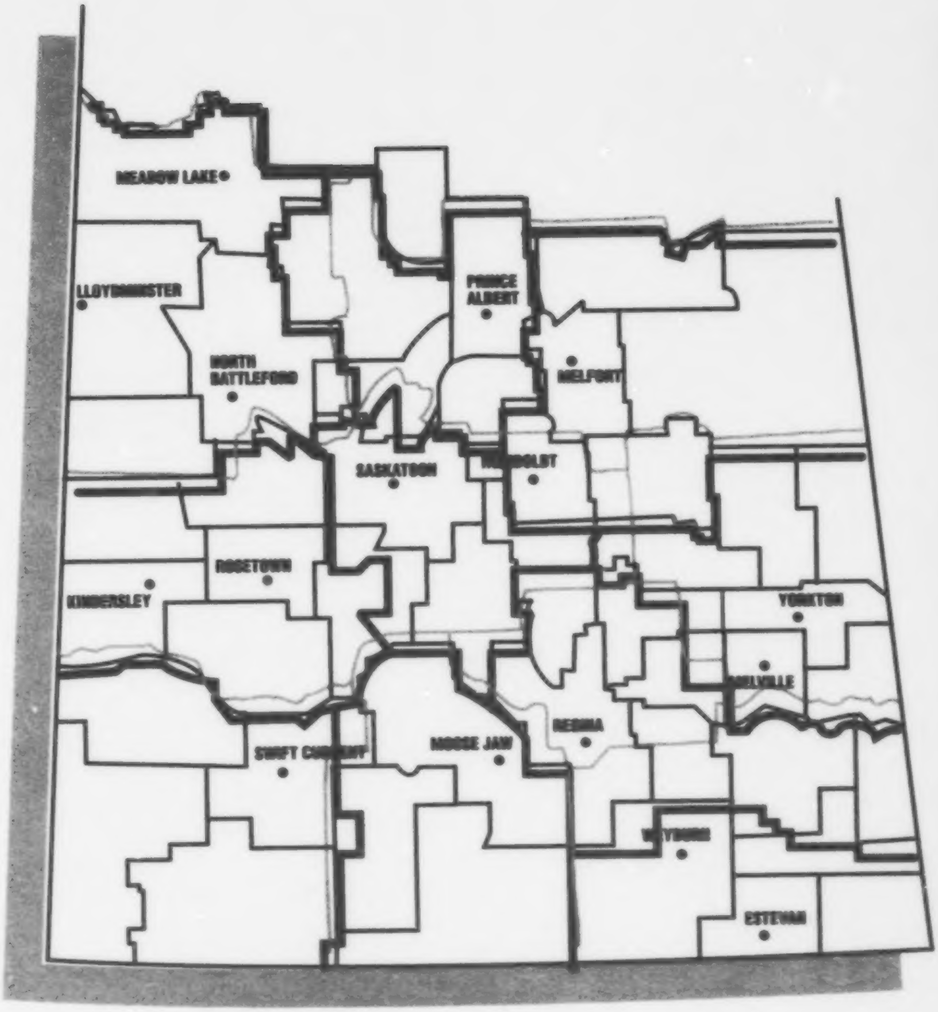
(b) The Department should provide direction for health promotion initiatives in the province, and initiate and deliver activities which require a provincial thrust.

(c) The Department should have total funding and administrative responsibility for payments for all insured programs which include physicians, chiropractors, and optometrists, as well as the Children's Dental Program and the Prescription Drug Plan, and should develop reporting mechanisms to regularly provide the division councils with information on service utilization.

(d) Provincial agencies responsible for delivering programs related to cancer and alcohol and drug abuse should continue to be accountable to the Minister of Health.

1.22 The Department of Health should continue to establish, monitor and regulate basic health standards to ensure that services provided by facilities and programs meet minimum standards, and that public health and safety are protected.

Exhibit A:
Administrative Regions for the Delivery of Community-Based Services, Saskatchewan Department of Health, 1990


MEADOW LAKE
LLOYDMINSTER
PRINCE ALBERT
NORTH BATTLEFORD
MELFORT
SASKATOON
HUMBOLDT
ROSETOWN
KINDERSLEY
YORKTON
MELVILLE
REGINA
SWIFT CURRENT
MOOSE JAW
WEYBURN
ESTEVAN

●	**Home Care**	**45 Districts**
●	**Mental Health**	**8 Regions**
●	**Community Health**	**10 Regions**

Exhibit B:
Administrative Districts for the Delivery of Hospital and Ambulance Services, Saskatchewan, 1990

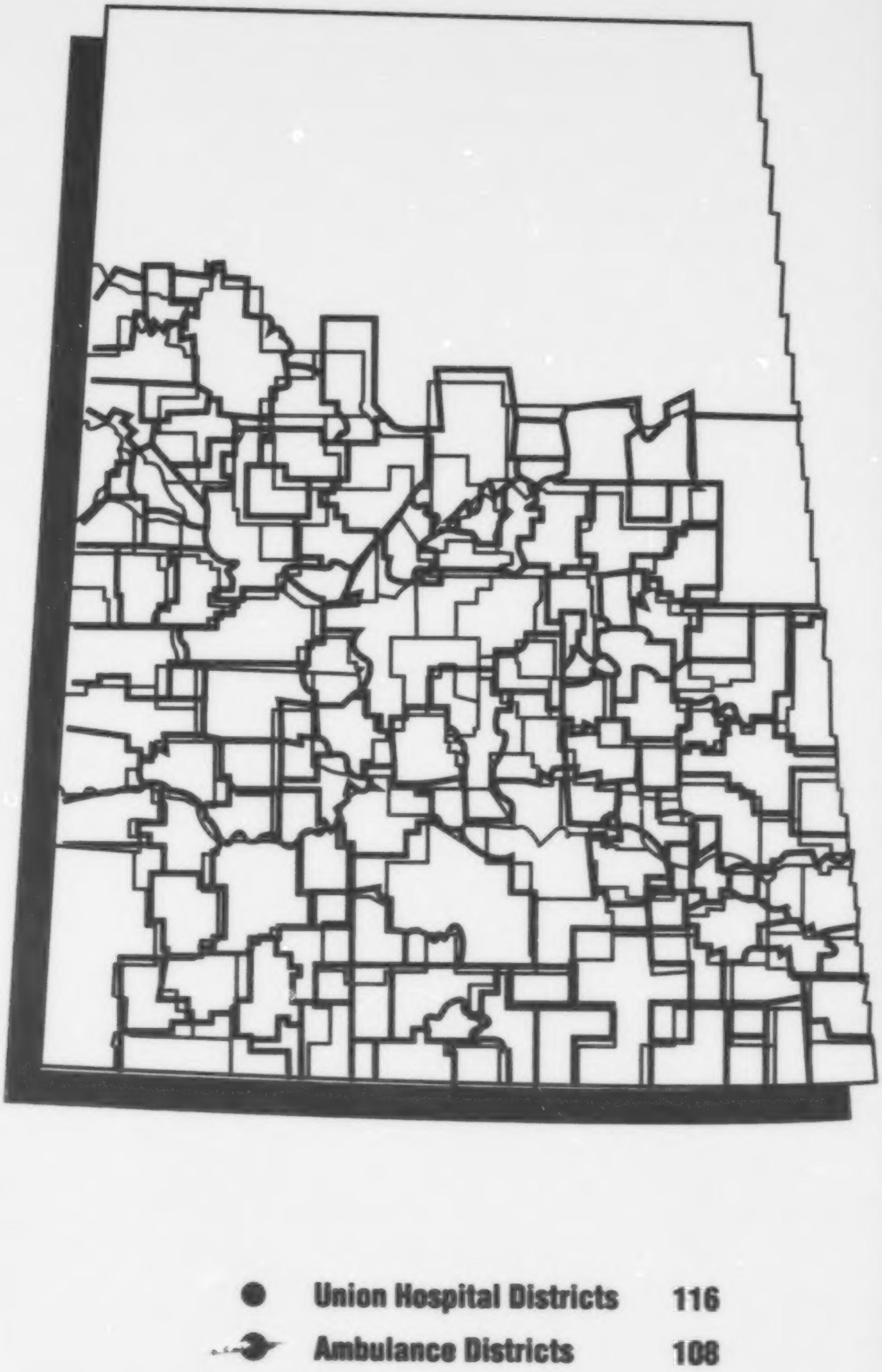
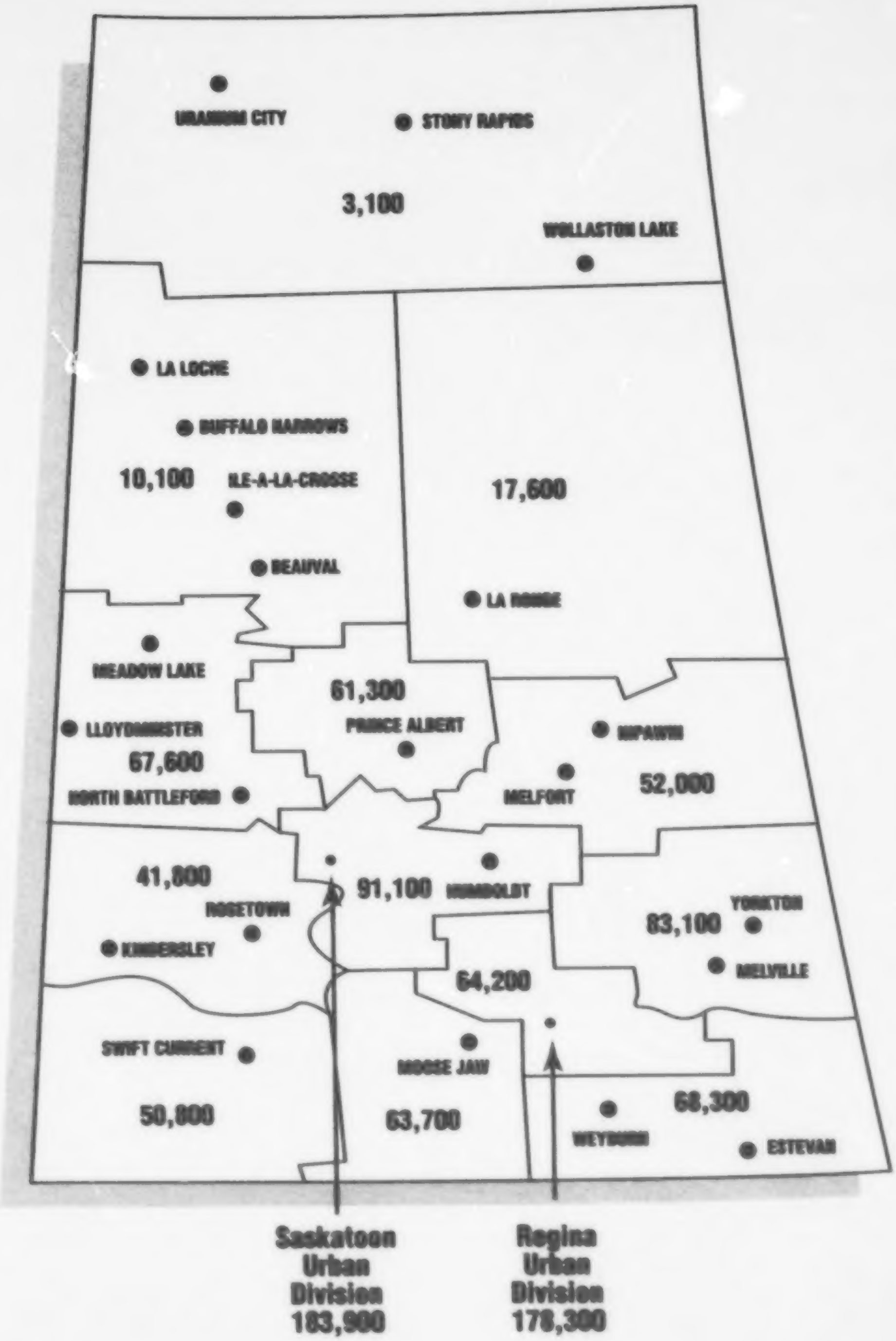

● Union Hospital Districts 116
Ambulance Districts 108

Exhibit C:
Proposed Health Divisions
for Saskatchewan


URANIUM CITY
STONY RAPIDS
3,100
WOLLASTON LAKE
LA LOCHE
BUFFALO NARROWS
10,100
ILE-A-LA-CROSSE
BEAUVAL
17,600
LA RONGE
MEADOW LAKE
61,300
PRINCE ALBERT
LLOYDMINSTER
67,600
NORTH BATTLEFORD
NIPAWIN
MELFORT
52,000
41,800
ROSETOWN
KINDERSLEY
91,100
HUMBOLDT
YORKTON
83,100
MELVILLE
64,200
SWIFT CURRENT
MOOSE JAW
50,800
63,700
68,300
WEYBURN
ESTEVAN
Saskatoon Urban Division 183,900
Regina Urban Division 178,300

Population figures from Saskatchewan Health Insurance Covered Population 1989

Exhibit D:
Illustrative Administrative Structure for a Division Council

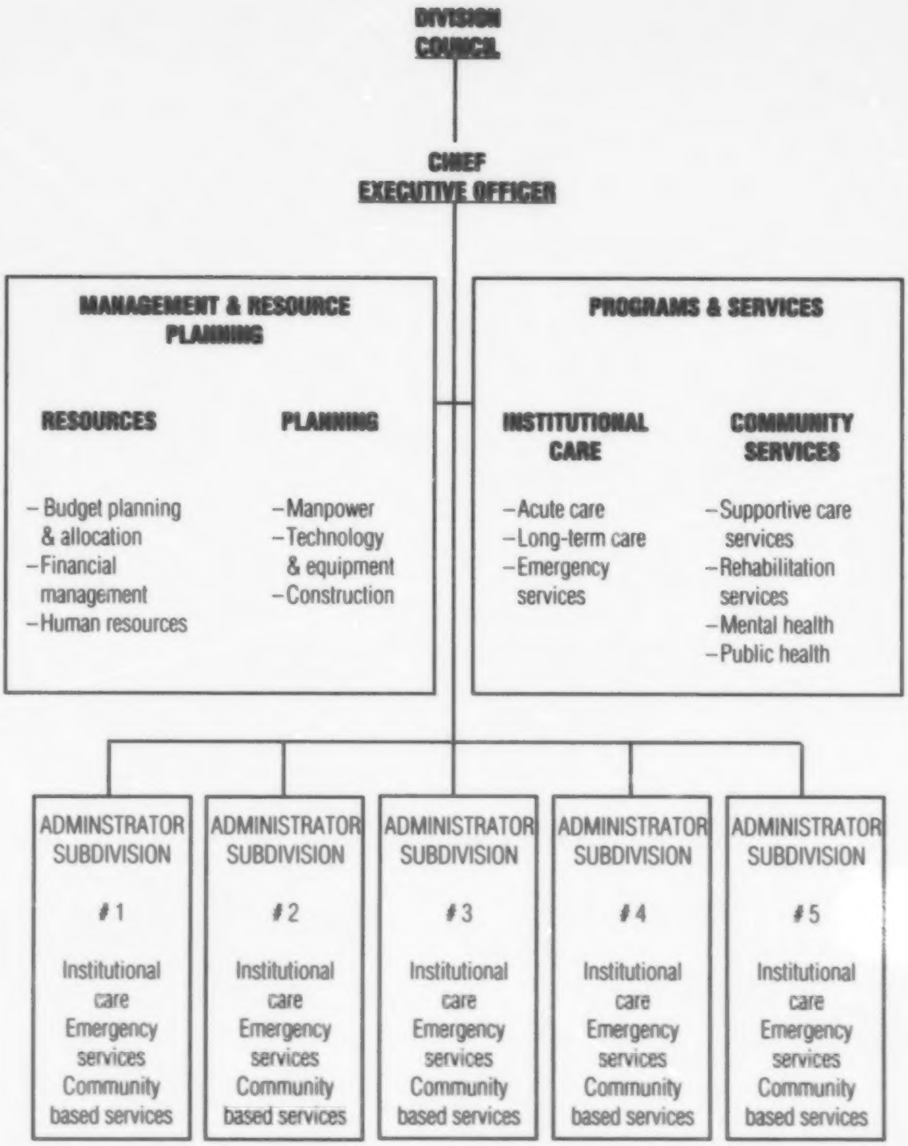
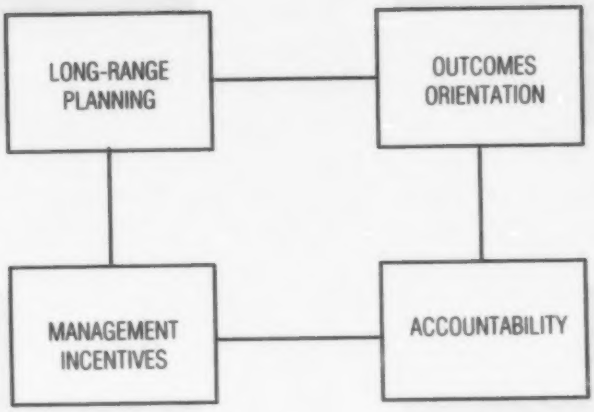

DIVISION COUNCIL
CHIEF EXECUTIVE OFFICER
MANAGEMENT & RESOURCE PLANNING
RESOURCES
– Budget planning & allocation
– Financial management
– Human resources
PLANNING
– Manpower
– Technology & equipment
– Construction
PROGRAMS & SERVICES
INSTITUTIONAL CARE
– Acute care
– Long-term care
– Emergency services
COMMUNITY SERVICES
– Supportive care services
– Rehabilitation services
– Mental health
– Public health
ADMINSTRATOR SUBDIVISION #1 Institutional care Emergency services Community based services
ADMINISTRATOR SUBDIVISION #2 Institutional care Emergency services Community based services
ADMINISTRATOR SUBDIVISION #3 Institutional care Emergency services Community based services
ADMINISTRATOR SUBDIVISION #4 Institutional care Emergency services Community based services
ADMINISTRATOR SUBDIVISION #5 Institutional care Emergency services Community based services

Exhibit E:
Corner Posts of
Budgeting Systems

CORNER POSTS OF BUDGETING SYSTEMS

DIVISIONAL


LONG-RANGE PLANNING
OUTCOMES ORIENTATION
MANAGEMENT INCENTIVES
ACCOUNTABILITY

PROVINCIAL

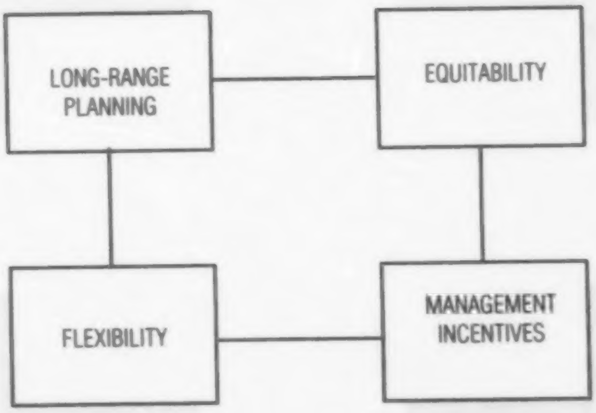

LONG-RANGE PLANNING
EQUITABILITY
FLEXIBILITY
MANAGEMENT INCENTIVES

Exhibit F: Local Governing Boards and Committees

PUBLIC LOCAL GOVERNING BOARDS

Proposed		**Existing**	
Division Councils	15	Hospital Boards	127
		Nursing Home Boards	133
		Home Care Boards	45
		Ambulance Boards	108
		Total	413

LOCAL MANAGEMENT COMMITTEES

It is proposed that the division councils should form management committees for large institutions or for groupings of smaller institutions. Between 25 and 30 such committees are expected to be established by the division councils.

2. Emphasis on Community and Supportive Living Services

Foreword
Focus on Better Health
A Comprehensive and Co-ordinated Community Program
Protection and Promotion of Health
Therapy and Rehabilitation Services
Health Care at Home
Support to the Family Caregiver
Enriched Housing
Organization of Mental Health Services
Exhibits

Foreword

Community health and supportive living services are all around us, but it takes care and determination to pick a path through the mixture of boards and districts and regions which provide them to actually tap into the services that are there.

For example, home care services are available in most of Saskatchewan, delivered by 45 independent boards. Mental health services are provided through eight regions of the Mental Health Services Branch. The Department of Health administers 10 regions which deliver assorted public health and therapy services; each has a statutory board of health. Regina and Saskatoon administer their own public health programs.

Community health services have long been the Cinderella programs of the provincial health system. Lip service has been paid to the idea that home care, rehabilitation services, well-baby clinics and mental health services are vital, but the funding has never matched the rhetoric. And in many ways these services have been invisible, because they are not connected to large and easily recognizable buildings like hospitals or long-term care centres but are delivered to the broadest possible mixture of locations, such as homes, schools, workplaces, shopping centres and recreation sites.

Community-based services are the kingpin of the health care system envisioned by the Commission and will be moved into the spotlight. Pulled together under a single umbrella in each division council, they will get the funding and attention they require, and that shift in emphasis will have a positive effect on the health of Saskatchewan people.

Innovative community-based services promise value for money spent, because they are directed first to keeping people healthy. When, eventually, health care of some kind is needed, services based in the community will provide just what is needed in a person's home or nearby, rather than in acute care or long-term care institutions.

From pre-natal classes and well-baby clinics to exercise programs and day and night centres for seniors, there must be continuity of community-based services, and those services must be flexible enough to respond to a person's needs as they are on a particular day. Perhaps tomorrow that person will need more services, or fewer. The system will adapt to the person, and not vice-versa.

Community-based services must be delivered by teams of people working together, not individuals whose dedication is worn out fighting battles on their own. Family members must be part of the team when they are caregivers, and attention must be given to their needs, e.g. respite. Scarce specialist professionals may be shared with hospitals or long-term care centres, or with other divisions.

Such services will focus first on health and health promotion, on the preventive steps that can keep people out of doctors' offices, hospitals and long-term care centres. Increased attention will be paid to such environmental issues as air and water quality, issues that may vary in different parts of the province. The needs of each division can be determined locally, through consultation with local people and experts, and with provincial input from the Department of Health to ensure a provincial system.

The important thing about community-based services is that they have targets: the promotion of good health and the reduction of illness to as low a point as possible, and certainly lower than in the past. The targets come first and must be chosen by the community for its own betterment. Then the professionals who are part of the public health or community health component take over; they aim programs and special initiatives at the targets of better health and less sickness and the overall goal of a healthy Saskatchewan.

Focus on Better Health

A number of presentations to the Commission expressed concern that the health care services provided in this province are never measured for results or outcomes. We are never sure that the initiatives we undertake are going to contribute to an improved environment and better well-being of individual citizens.

Most other major enterprises usually identify goals which are to be achieved within a certain time. Again, this is not characteristic of the health care system that has developed in Saskatchewan particularly, or in Canada generally. Rarely is a program designed to reduce specific factors that cause deaths, or alter circumstances that contribute to a deterioration of health.

It is also evident that only recently has there been awareness of the effects that initiatives and policies in the private or public sectors can have on the health and well-being of individuals. Over the years, little concern has been expressed about factors which might pollute our water supply or contribute to the deterioration of the quality of the air we breathe, or even those which contribute to violent deaths or long-term suffering.

The Commission was impressed with the number of people who suggested that those responsible for the health care system of this province must make decision-makers, societal agencies and individual citizens more conscious of the effects that their actions might have on the health and well-being of our residents.

RECOMMENDATIONS

2.1 **The Department of Health must establish a set of specific health targets which would be the foundation for provincial programs, initiatives and budget priorities, and which would serve as a guide to division councils in establishing their health promotion and other programs.**

(a) Such targets should be specified for achievement over five-, 10- and 15-year periods.

(b) A major factor helping to determine such targets should be the health status surveys done by the Health Analysis and Development Commission. (See Section 5).

(c) Funding policies should be developed by the Department of Health which encourage each division to take imaginative initiatives to achieve health targets.

(d) Such targets should be specific and should identify risk factors contributing to illness and mortality rates in areas such as traffic accidents, lung cancer, breast cancer and heart failure.

2.2 **Each division council should develop strategies to meet provincial health targets, identify specific targets which particularly reflect the needs of its area, and develop programs and initiatives involving communities and individuals in activities designed to achieve those targets.**

(a) Councils should develop a system of initiatives to encourage communities to try innovative approaches to achieve the specified targets.

2.3 **The Health Analysis and Development Commission (See Section 5) must have as one of its responsibilities the monitoring of provincial and local government policies and initiatives which are outside of the health care field but which can, when implemented, have an adverse effect on the health and well-being of Saskatchewan residents.**

(a) The Commission's annual report to the legislature should refer to and, where appropriate, express caution about industrial, commercial and public undertakings which could undermine good health.

2.4 The Health Analysis and Development Commission should undertake a health status survey of the Saskatchewan population every five years to evaluate the effectiveness of programs undertaken to improve health and to determine those groups within the total population which might be at particular risk and require special programs.

(a) The insights gained from the health status surveys should form the basis for program changes at the provincial and division levels.

A Comprehensive and Co-ordinated Community Program

Community services are currently provided by a wide variety of health professionals and agencies. For example, traditional public health services such as inspection and public health nursing are offered to rural Saskatchewan by the Community Health Services Branch of the Department of Health; mental health services are delivered by the Mental Health Services Branch of the Department; home care is provided by locally-governed boards. Furthermore, a number of non-government organizations (NGOs) provide a wide variety of support services.

This segregation of services has resulted in fragmentation and limited opportunity for a co-ordinated team approach in delivering health care to residents. This contributes to serious gaps in service, and public confusion in accessing services.

There is a tendency for managers and health care providers to think of community-based programs within the narrow confines of the home care, mental health, public health or non-government organization sectors. Community-based services are unfortunately more of a mosaic than a system. Consequently, community volunteers, health professionals and families cannot always co-ordinate their efforts to allow people to live and attain health in as normal settings as possible.

The Commission received many briefs from public health, community nursing and home care representatives who stressed the tremendous potential of community services to focus upon critical and emerging health issues, such as programs to protect and promote health, and caring for people at home rather than in hospitals and long-term care centres. All said that community-based services need to be given the same high profile and funding priority as the institutional sector if the health system is to move forward.

Inadequate attention has been given to the organization, co-ordination and consolidation of this key health delivery sector. A framework is needed which encompasses all programs delivered in the community. There is a need to develop a cohesive team of health care providers, including volunteers, who share a commitment to emphasize wellness and independence rather than sickness and dependence.

Only with imaginatively operated and properly funded community-based services which respond to people's real needs can the continuity of care that is crucial to tomorrow's health system be ensured, and only then can the over-use of institutions be eliminated. This must be the strong front line of our health care system.

RECOMMENDATIONS

2.5 A comprehensive, co-ordinated and integrated program of community health and supportive living services, focused on promoting health and fostering independent living, must be developed in each division to meet as many health needs of the total population as possible.

(a) The total community health services program package should incorporate the elements now found in public health, chiropody, community therapy, and health promotion.

(b) The program must be expanded to include home care, community mental health services, support for family caregivers, and aids to independent living to further reduce the dependence on institutional care.

2.6 A community health services unit should be established in each division to plan and direct the various programs which require specially-trained health professionals, and to co-ordinate community services with hospitals and supportive care centres (Refer to Recommendation 3.30) on behalf of the consumer.

(a) The head of the community health services unit would be a program director reporting to the chief executive officer of the division council.

(b) The professional team should include people trained to deliver nursing, rehabilitation, inspection, health promotion and education, mental health, counselling, and home support services.

2.7 Each division should establish a standing committee on community health services to ensure those services are highlighted in its programs and delivered in a responsive and co-ordinated way.

(a) The division council should appoint one of its members annually to chair the committee, which should include representatives of professional and community groups with special interest in public health, home care and rehabilitation services, and a representative from the mental health advisory committee. (Refer to Recommendation 2.41).

(b) The committee, consisting of seven to nine persons, should be appointed by the division council for a three-year term.

2.8 A mechanism should be established within the community health services unit of each division to provide a convenient entry point for people requiring supportive living services at home and/or supportive care centre placement, and to assess their needs, abilities, and the supports available to them in order to determine their unmet needs.

(a) Provincial assessment criteria should be developed jointly by the Department of Health and the Division Council Co-ordinating Board.

(b) Each division should designate an administrator of assessment responsible for:

(i) setting up local assessment teams consisting of professionals from the hospital, long-term care, therapy and mental health sectors.

(ii) administering policies for managing complex cases, placement in supportive care centres, delivery of respite care and palliative care.

(c) Each assessor should be required to complete an assessment training program offered by the Department of Health which is directed at developing assessment skills and knowledge, and which is based on a provincially-applied assessment policy.

2.9 A toll-free telephone line should be established under the auspices of the community health services unit of each division to provide health consultation and health services information to residents.

2.10 To enrich the personal dimension of the supportive living programs offered and to encourage a sense of neighborly responsibility, each division must encourage, organize and co-ordinate community volunteers.

Protection and Promotion of Health

The Commission heard appreciation expressed for the contributions made by medical health officers, public health inspectors, public health nurses, and other health care professionals associated with the community health program. There is little doubt they have made considerable progress in reducing certain causes of death, in eliminating hazards adversely affecting health and in contributing to a greater consciousness among people generally about leading healthier lifestyles.

On the other hand, a number of briefs suggested a variety of factors and conditions have not permitted the public health programs to keep pace with changing circumstances and expectations. In many instances the mandates have not been expanded in any significant manner. There also has not been any substantial change in how services are delivered. In other words, the public health sector seems to have a tendency to speak of the future in terms of the accomplishments of the past.

The Commission also noted that public health has been losing ground in the past few years in relationship to other areas of health. Its share of the budget has slipped and the number of positions allocated to public health has been reduced.

It became evident that in charting the course for public health services in the future, several very important factors of our society must be taken into consideration. These include the greying of the population, particularly in rural Saskatchewan, increasing awareness of the detrimental effects of certain environmental conditions and the expressed desire to see a greater focus on health rather than on health care. All these suggest the need for an examination of how we deliver services, what the services are, and to whom we deliver them.

RECOMMENDATIONS

2.11 The mandate of the traditional public health programs should be expanded to place much more emphasis on health promotion and maintenance of good health, through such programs as disease prevention, public education, personal and group counselling, and monitoring of environmental and community factors which affect the health of individuals.

(a) These specific services should be targeted at increasing people's sense of responsibility for preserving the health of their community and their personal good health.

2.12 Each division should take a team approach to the delivery of public health services to ensure co-ordination and integration, and should foster increased personal knowledge of the many factors which affect health.

(a) The core health professional team should include a medical health officer, nurses, environmental health officers (public health inspectors), nutritionists, health educators, and dental health educators.

(b) The numbers of staff, particularly in health education and nutrition, should be increased to enable these health professionals to play a greater and more effective role in health promotion.

2.13 The medical health officer employed by each division council should have overall responsibility for the focus and direction of public health services within the division, with special emphasis on strategies for disease prevention and health promotion.

(a) The medical health officer should have specialized training in the public health field.

(b) The medical health officer must have responsibility and authority for enforcing the provisions of The Public Health Act.

2.14 A community nursing program should be developed which serves both the public health and home care components of the community-based program, and provides an integrated and co-ordinated approach in the delivery of services to the total population, from pre-school children to seniors.

(a) The community health nurse's mandate should be defined in a broader way to ensure the same person may provide a variety of basic nursing services in a particular community or situation. For example, a community health nurse on a post-natal home visit may also attend to the needs of an infirm senior in that home.

(b) The services of community nurses should be delivered through a variety of activities and settings, including schools, special clinics, public lectures, group counselling, and home visits.

2.15 The public health inspector's role should be expanded to clearly indicate a responsibility to monitor, inform and educate about a broad spectrum of environmental factors in the immediate community which affect the health of individuals.

(a) The position of public health inspector should be renamed environmental health officer.

(b) Training and in-service programs should include environmental issues.

(c) Major industrial and commercial projects should remain a provincial responsibility attached to the Department of Environment and Public Safety.

2.16 The public health team of each division must include a health education officer(s) responsible for developing health information, promotion and counselling services, having direct contact with individuals, groups and institutions within the community, and serving as a resource person to other health care professionals.

(a) The health education programs developed for a particular division must reflect its special needs and priorities.

(b) The health education officer should involve other health care professionals in the division as resource persons to conduct clinics, provide counselling, and give presentations about the division's health education priorities.

2.17 Each division council should develop and implement detailed health promotion strategies which are specifically designed to improve the health of its residents and which provide for broad community involvement.

(a) Division health promotion strategies should complement and supplement the provincial strategy which is the responsibility of the Department of Health.

2.18 The Department of Health should allocate adequate funding for all health promotion activities in the province, based on department and division council plans for a dynamic program focusing on the maintenance of good health by each citizen.

(a) The total provincial health promotion fund should be determined on the basis of $10 per capita.

(b) The allocation to division councils for their overall promotion programs and specially-designed initiatives should amount to 50% of the total health promotion fund.

2.19 Division councils should be sensitive to the special needs of such groups as natives, children and adolescents, and various ethnic groups in accessing health services, and should develop ways to help them receive services and maintain good health to the greatest degree possible.

(a) Division councils should employ native liaison workers on the basis of the assessed special needs of their native populations to provide a link between native clients and the health care system; to assist natives to get health services; to provide follow-up to treatment; and to educate natives about healthy lifestyles.

(b) Division councils should work with local ethnic organizations to encourage their volunteer involvement in assisting ethnic residents to obtain health services and information.

(c) Information and counselling services available for children and adolescents should be widely publicized so youth and parents can comfortably and conveniently access services.

Therapy and Rehabilitation Services

In the presentations made to the Commission, one of the areas identified time and again as requiring attention was that of therapy and rehabilitation services at the community level, especially in rural Saskatchewan. Particular concern was expressed about the availability of and accessibility to physical and occupational therapy services.

Rural residents are frequently required to travel significant distances to receive necessary therapy services. Furthermore, because of the lack of available services, treatment is often irregular and infrequent, and patients are unable to receive therapy according to a prescribed or recommended schedule of treatment.

The Community Therapy Program implemented by the Department of Health in 1986-87, which has taken physical therapists and occupational therapists to 130 communities in Saskatchewan, has been very well received. However, it has also contributed to the realization that the program has to be significantly expanded if it is to meet the legitimate needs and demands of Saskatchewan residents, particularly the elderly and the disabled.

One of the most obvious needs is to increase the number of physical therapists and occupational therapists in the province and to better integrate their services with those of other community health professionals.

In addition, the current mix of physical therapists and occupational therapists needs to be reviewed, with greater recognition given to the importance of occupational therapy in the rehabilitation of many individuals, particularly the elderly, the disabled, special needs children, and the head injured. A strong occupational therapy program can contribute significantly to enabling many individuals to remain out of institutions and lead productive, fulfilling lives.

Speech and language therapy services also need expansion and integration with other community-based programs and services. Currently, speech and language services are provided by the Community Health Services Branch of the Department of Health in rural Saskatchewan, although they do not form part of the community therapy program. Services are primarily targeted at pre-school children, with services to school-age children generally being the responsibility of individual school boards. The adult population receives its services primarily from speech and language pathologists employed by the larger health care facilities.

Considerable concern was expressed in the briefs to the Commission about the lack of co-ordination among the agencies and staff providing speech and language services, and the resulting frustrations and gaps in service. The other major concern was about the shortage of speech and language pathologists in the province, and the resulting inadequacy in the availability of and accessibility to services.

The cities of Saskatoon and Regina do not provide any therapy services through their community health programs; patients requiring such services as physical therapy, occupational therapy, or speech and language therapy are referred to other agencies, such as the Wascana Rehabilitation Centre and the Wascana Home Care District in Regina, and the Rehabilitation Outreach Program in Saskatoon. Consequently, services in the two cities seriously lack co-ordination, and there are long waiting lists. Furthermore, considerable emphasis is placed on institutional treatment services.

In order to allow disabled residents to stay out of institutions and to assist them to become and remain productive members of society, it is critical that strong community-based therapy programs are made available in both rural and urban Saskatchewan.

RECOMMENDATIONS

2.20 Each division council should offer a community therapy program as part of its community-based services package designed to meet the special needs of all division residents, with a core team of physical therapists, occupational therapists, and speech and language pathologists.

(a) Community therapy services should be provided on an outreach basis to community hospitals, supportive care centres, family health care centres and private homes.

2.21 A clear policy and understanding should be developed between each division council and the school boards within the division, stipulating that community therapy services for pre-school children and adults and all institution-based therapy services are the responsibility of the division council, and services to school-age children outside of health care institutions are the responsibility of the respective school boards.

(a) Each division council should develop a co-ordinating and monitoring mechanism with the school boards in the division to ensure services are co-ordinated and gaps do not occur.

2.22 To ensure an adequate supply and mix of community-based rehabilitation personnel, each division should establish criteria for determining staff levels for therapy positions, which take into consideration the total population and special circumstances peculiar to that division.

2.23 To enhance and ensure adequate delivery of physical and occupational therapy services, the therapy team should include therapy technicians who would provide services under the direction of professional therapists. (Refer to Recommendation 4.46).

2.24 Division councils should be responsible for acquiring and distributing equipment provided through the Saskatchewan Aids

to Independent Living (SAIL) program for use by individuals residing in private homes, group homes and supportive care centres.

(a) The Department of Health should be responsible for centralized purchasing and for a central warehouse and repair depot.

Health Care at Home

The home care program has evolved into one of Saskatchewan's most popular and cost-effective health programs. The support services provided by home care offer an attractive alternative to costly institutionalization for residents requiring assistance to live independently.

The Commission learned that there is a special appreciation for the basic services provided by home care. These services currently include assessment and care co-ordination, homemaking, meals, nursing, and limited home maintenance. Some urban districts also provide physical therapy, occupational therapy and social work.

Volunteers play an important role in home care services in such areas as administration, meal delivery, friendly visits, transportation, home maintenance and telephone surveillance. According to a Saskatchewan Home Care Association report, more than 18,000 volunteers provided 126,000 hours of service province-wide in 1988.

Although its services are available to anyone requiring them, there has been a tendency for home care to be viewed as a 'seniors' program. In 1987-88, 85 per cent of clients were 65 and over. Unquestionably, due to the disabilities and diseases associated with aging, seniors will continue to be the main recipients of home care services. However, many other individuals could also benefit from home support programs, and more consideration needs to be given to the supportive living needs of disabled young adults and children, the mentally handicapped, and individuals suffering (or recovering) from mental illness.

In some areas, district co-ordinating committees have worked very successfully to co-ordinate the assessment and care functions of the home care, long-term care and acute care sectors within communities. However, home care continues to be locally administered by a separate board. Furthermore, within the Department of Health, administration of home care is the responsibility of the Continuing Care Branch. This produces a situation in which the home care program is too often separated from other programs, especially other community-based programs.

This situation contributes to gaps in service, lack of co-ordination, particularly with other community-based services, and inefficient use of staff resources. Integration and co-ordination of home care with other community-based services could contribute significantly to a continuum of care, to a holistic approach to treating and serving clients, and to more efficient and effective utilization of staff.

During the Commission's public hearings, the demand for a more comprehensive and improved system of health care at home was emphatically expressed. The Commission strongly supports a comprehensive home care program as it provides a means of keeping people out of costly institutional beds, while providing them with quality of life.

RECOMMENDATIONS

2.25 **The home care program in each division should provide a full range of health care and other supportive living services to all residents, including the elderly, the young disabled, the mentally handicapped, the mentally ill and those with head injuries, who require these services to remain independent and at home for as long as possible.**

2.26 **The home care program in each division should include nursing, home support, and rehabilitation services delivered through a combination of staff and volunteers recruited by the home care program as well as other community-based programs and agencies.**

(a) The core services provided should include:

- Nursing services: administration of medication, intravenous therapy, and health counselling.
- Home support services: homemaking, home maintenance, personal care, mental health support, emergency monitoring and response systems, friendly visiting, meals on wheels, transportation and in-home respite services (See next chapter, Support to the Family Caregiver).
- Rehabilitative services: physical therapy, occupational therapy, speech and language pathology (See previous chapter, Therapy and Rehabilitation Services).

(b) Home support services should be provided by personnel and volunteers recruited by the home care program, whereas nursing and rehabilitation services should be co-ordinated with and made available through the community nursing and community therapy programs.

2.27 **User fees for home care services, based on the principle of accessibility, should be established on a province-wide basis to ensure equity for clients and division councils.**

(a) There should be no charges for nursing and rehabilitative services.

(b) There should be charges for certain home support services such as home maintenance and meals on wheels.

2.28 To provide a sense of security to caregivers and dependent people living at home, personal emergency response systems - electronic devices which connect their wearers with the nearest hospital or other designated emergency monitoring centre - should be introduced as part of the home care program within each division.

(a) Division councils should develop a plan for a reasonable monthly charge to users of personal emergency response systems.

Support to the Family Caregiver

The extent to which disabled young adults and children and the elderly are able to live in a home environment depends largely on the support services available within the community and on the availability of an in-home caregiver. This latter responsibility more often than not falls on a family member, such as a spouse, parent or adult child.

There are many pressures associated with caregiving.

Financially, there are the potential costs of special equipment, supplies, and medication. In some situations, the need for a caregiver to remain at home may mean loss of a source of income for the family.

The demands of caregiving frequently affect the social life of the caregiver, whose opportunities for involvements outside the home become difficult and seriously restricted. This often means a loss of friends and other social contacts.

Perhaps the most common and significant consequence of caregiving is the related emotional stress. Caregivers frequently lack knowledge and understanding of the patient's physical, mental, and/or emotional condition. This, combined with the demands placed on the caregiver by the dependent person and the corresponding emotions involved in caring for a loved one, results in tremendous stress.

The current system provides minimal support and incentives for people to undertake family caregiving responsibilities. The Commission received presentations from a wide variety of groups and individuals expressing the need for caregiver support systems, particularly respite care. Many kinds of respite needs were identified, ranging from relief during nights, to lengthy vacation relief, to a few hours of babysitting services required by parents of autistic children.

Respite services are available in varying degrees across the province; however, much more accessible, flexible and responsive respite arrangements are required.

The Commission was also made aware of the need for assistance for family and friends of individuals requiring palliative care. Many people prefer to spend their remaining days at home or as near to home as possible. This frequently places close family and friends in the difficult position of wanting the loved one near them, but lacking the support services to enable that to happen.

Strategies must be developed which assist and encourage families and friends to assume the role of caregiver in the home. The key to a successful support system is that services must focus on the caregiver.

RECOMMENDATIONS

2.29 Each division council should develop, as part of its home care program, a comprehensive support system for family caregivers which is specifically targeted to the caregiver and provides access to respite services, counselling and educational services.

(a) Support services should be made available to caregivers of the elderly, physically disabled, mentally handicapped, head injured, and mental health clients.

2.30 A health care co-ordinator within the home care program should be assigned as the primary contact for each family caregiver, to regularly communicate with and counsel the caregiver to ensure his or her needs are met, and to help obtain necessary services for the dependent individual.

2.31 Each division council should ensure that a wide range of respite services is available and accessible to all family caregivers on the basis of assessed and varying needs, and recognizing the unique care and social needs of the dependent individual.

(a) Division councils could locate respite beds in a variety of settings such as supportive care centres, licensed private care homes, comprehensive family health care centres and other designated health care facilities, and on a limited basis in community hospitals, depending on the availability of such facilities and on the caregiving needs of the communities.

(b) Respite services should be available within the caregiver's home, whenever this is more practical or advantageous.

(c) Respite services should be available on short notice, and for periods ranging from a few hours to three to four weeks, and during nights.

(d) Criteria for the receipt of respite services should be developed within each division, based on the assessed and recognized needs of the caregiver and with no restrictions based on the age or disability of the dependent individual.

2.32 To alleviate the stress caregivers experience because of their concern for the proper care of dependents, educational and counselling services should be provided through the home care program in each division.

(a) Educational services may include workshops which focus on caregiving techniques, handling stress, and other related topics.

(b) Counselling support services provided by professionals such as mental health workers, social workers, and nutritionists should be made available and co-ordinated through the health care co-ordinator.

2.33 For daily relief for family caregivers and to provide dependent adults with social, recreational and rehabilitative opportunities, adult day/night care centres reasonably accessible to families requiring such services should be established in each division.

(a) Adult day/night care centres may be located in a number of settings, including family health care centres, seniors' complexes and other designated community facilities.

(b) Provincially established standards should be developed to ensure minimum program and staffing requirements are met.

2.34 Division councils should establish a system of fees for respite and adult day care which will not, however, create an incentive for institutionalization and which do not exceed resident charges at supportive care centres.

2.35 A comprehensive palliative care program should be developed within each division with a range of services for home support, pain and symptom control, psychological care and bereavement aimed at meeting the needs of the terminally ill and their immediate family and friends.

(a) Palliative care should be available in a number of settings, but most particularly at home, in community facilities offering health care services, and in community hospitals.

(b) The program should facilitate movement of the patient between home and hospital, as the patient's and caregiver's needs change.

(c) Consultation or "symptom control" teams of clergy, nurses, physicians, social workers and others with skills in the care of the dying should be established in each division to provide inpatient and outreach counselling and advice to patients and families.

Enriched Housing

The combination of a strong community supportive living system and available housing is vital to any efforts to help people remain in their communities rather than enter a long-term care centre.

Many people, particularly seniors, rely on government-sponsored programs to meet their housing needs. The Saskatchewan Housing Corporation provides subsidized and enriched housing units in communities throughout the province. It sponsors housing projects on the basis of requests and directions from some 280 local housing authorities.

The local housing authorities operate independently of each other, and hence there is little co-ordination and complementarity in the initiatives undertaken in different communities.

The Commission believes that division councils must be responsible for developing programs and strategies to help people who need living supports remain in their homes for as long as possible. It urges the councils to develop strong community support services, and to ensure that options for accommodation - such as group homes - are available.

Unquestionably, enriched and senior housing are integral elements of this community-based approach.

Clearly, the Saskatchewan Housing Corporation must continue to have overall responsibility for these programs. However, mechanisms must be put in place to ensure that projects and strategies undertaken by Saskatchewan Housing and the division councils complement and coincide with each other. Such mechanisms must contribute to co-ordination and planning on a divisional basis.

RECOMMENDATIONS

2.36 An ENRICHED HOUSING COMMITTEE should be established by the Saskatchewan Housing Corporation within each health services division to co-ordinate housing initiatives, and to make recommendations about development of housing programs and construction of housing.

(a) Each eight or nine-member committee should include three representatives nominated by the division council, and one representative from a community housing authority in each sub-division.

(b) The committee chairperson should be selected by the Saskatchewan Housing Corporation.

(c) Each committee should seek division council endorsement of its housing strategies before making recommendations to the Saskatchewan Housing Corporation.

Organization of Mental Health Services

Representatives of the Saskatchewan Branch of the Canadian Mental Health Association, as well as representatives of the local branches, made numerous presentations to the Commission on the state of mental health services in Saskatchewan communities. In addition, individuals associated with local community agencies addressed the needs of the mentally ill in a number of briefs. In all cases, serious inadequacies in mental health services, particularly at the community level, were cited.

Whereas Saskatchewan was once considered an innovator and leader in the mental health field, this province has seen virtually no advances in mental health for many years, and in fact, services to the mentally ill have declined. In the total spectrum of health care services, those who suffer with mental illness have appropriately been identified as the "forgotten constituents".

The Commission became aware of many inadequacies with respect to the mental health programs and services.

The Saskatchewan Plan, implemented during the 1960s, established the foundation for a new and improved approach to the treatment of the mentally ill. The Plan, which rejected institutionalization, was exciting and a tremendous step forward in mental health treatment. As a result of it, the inpatient population of psychiatric facilities was reduced from 3,111 to 931 between 1963 and 1971, and is currently at 185.

Unfortunately, the resources necessary to treat and support mental health clients in the community were not injected into the system. Instead, the budget history of mental health services indicates a dramatic decline in resources, by comparison to percentage increases in other sectors of the health field.

The results of the inadequate resources are serious underservicing in many instances, a lack of rehabilitative and supportive living services, and mental health facilities, which are frequently inferior in appearance, furnishings and maintenance.

Other inadequacies and problems compound the difficulties faced by the mental health system:

Many services are developed through initiatives taken by local community agencies and groups, and as a result, the comprehensiveness of the services available varies dramatically from one area of the province to another.

A serious problem exists in our ability to recruit mental health professionals, particularly psychiatrists and psychologists.

A stigma continues to surround mental illness.

Because of the nature of the illness, mental health clients are unable to effectively advocate for themselves.

The Commission struck a special committee to examine the delivery of mental health services. The committee visited a number of mental health facilities and met with people in the field from outside Saskatchewan as well as those involved in delivering services within the province. It studied and analysed a variety of efforts made in several places to improve services for the mentally ill.

The Commission concluded that some very special initiatives must be taken which will increase the community sense of responsibility for the welfare of the mentally ill, and raise among provincial and local decision-makers a consciousness of the needs of this group.

RECOMMENDATIONS

2.37 A new provincial organization entitled the SASKATCHEWAN MENTAL HEALTH COMMISSION should be created for the purpose of recommending provincial initiatives in mental health; monitoring mental health services in the province; establishing mental health standards; sensitizing the public and decision makers regarding mental health issues; and serving as an advocate for both mental health clients and service providers.

(a) The 10-member Commission should be comprised of five chairpersons of the division council mental health advisory committees, named by the Division Council Co-ordinating Board; the Professor and Head of Psychiatry, University of Saskatchewan; and one representative of each of the Saskatchewan Branch of the Mental Health Association, the Saskatchewan Psychiatric Nurses Association, the Saskatchewan Psychologists Association, and the Saskatchewan Association of Social Workers.

(b) Appointments should be for three-year terms, with eligibility for re-appointment for a second term.

(c) The Commission should elect its own chairperson annually.

(d) The Commission should serve in an advisory capacity to the Minister of Health and the Division Council Co-ordinating Board, and should submit to both an annual report on its activities, observations and analyses, and its recommendations.

2.38 The Department of Health, in partnership with the division councils and the Saskatchewan Mental Health Commission, must develop a mental health plan of action which extends over the next decade, and which results in the transfer of responsibility for the delivery of mental health programs and services from the provincial to the divisional level.

(a) Institutional care, outreach and community-based programs and services, which are now the responsibility of the Department of Health, must become the responsibility of individual division councils.

2.39 A network of psychiatric institutional care should be developed by the Department of Health and the division councils which will provide for varying levels of treatment and rehabilitation services throughout the province to meet the many different needs of the mentally ill.

(a) A 12-15 bed evaluation unit, with one stream for adults and another for children and youth, should be established in conjunction with the University of Saskatchewan for early intervention in the most difficult cases.

(b) A special needs assessment and rehabilitation unit with 15-20 beds should be developed at the Wascana Rehabilitation Centre in Regina for younger seriously cognitively impaired individuals, with mental handicaps or other disorders.

(c) A 15-20 bed special needs assessment and rehabilitation unit should be established at the Parkridge Centre in Saskatoon for elderly persons with cognitive impairments and related special needs.

(d) Residential units, with appropriate supportive living services, should be established within each division, with 20 beds in each of the Saskatoon and Regina divisions designated for those mentally ill persons from northern and southern Saskatchewan, respectively, who have special intensive needs.

2.40 Saskatchewan Hospital North Battleford should be designated as a forensic mental health facility for young and adult offenders, and no new residents should be admitted there except for those admitted through a lieutenant-governor's warrant, and others requiring a forensic mental health program.

(a) Division councils should become directly responsible for providing residential and institutional care to those mental health clients who normally would have been admitted to Saskatchewan Hospital North Battleford (with the exception of forensic patients).

(b) Mentally handicapped patients, dually diagnosed as suffering from mental illness, should be admitted to the Valley View Centre in Moose Jaw.

2.41 **Each division council should establish a SPECIAL MENTAL HEALTH ADVISORY COMMITTEE as part of its administrative and delivery system, in order to facilitate co-ordination and integration with other community services and maximize public awareness and sensitivity to mental health issues.**

(a) The advisory committee should consist of representatives of the general public, interest groups, and health professionals, and should be chaired by a division councillor.

(b) The primary role of the advisory committee should be to serve as an advisory body to the division council and as an advocate on behalf of patients.

2.42 **Each division council should develop a mental health charter which would provide the basis for its strategy in addressing the needs of the mentally ill in its communities.**

(a) The basic principles in the charter should include the following:

- Recognition of the multi-dimensional nature of mental illness, and that individual citizens have differing and changing needs.
- Recognition of the legal rights of mental health clients.
- Commitment to the integration and mainstreaming of mental health services.
- Commitment to a community-based approach in the delivery of services.

2.43 **Each division council should develop a well-defined and long-term plan for the provision of mental health services, which includes a range of community-based supportive living, rehabilitation, community outreach, outpatient, and acute inpatient treatment services, as well as a public education strategy to increase public sensitivity and understanding of mental illness.**

(a) An interdisciplinary team approach to the delivery of services should be adopted which provides for the involvement of a wide range of professionals, including psychiatrists, psychologists, family physicians, psychiatric nurses, social workers, and other community-based personnel, such as home care workers and therapists.

(b) To direct its mental health program, each division council should directly employ a psychiatrist, supported by an appropriate mix of professional and paraprofessional staff, including psychologists, psychiatric nurses, social workers, occupational therapists, recreational therapists, and community mental health workers.

(c) A strategy involving employers in the private and public sectors should be developed within each division to assist in the re-entry of the mentally ill into the mainstream of the workforce.

(d) Division councils should enter into twinning arrangements with each other to facilitate the provision of specialized services.

2.44 **To give mental health greater prominence at the local level, and to ensure an array of support services is available to community residents suffering from mental disorders, mental health programs and services should be mainstreamed with the health programs delivered by each division council.**

(a) Mental health services within each division should be co-ordinated and integrated with other health services, and most particularly with community-based services.

2.45 **Each division council must make a special effort to provide supportive living services to mentally ill individuals as part of its home care program, in order to assist them to live in a community setting, as independently as possible.**

(a) A class of paraprofessionals called **community mental health workers** should be established whose primary responsibility would be to provide home care support to the mentally ill.

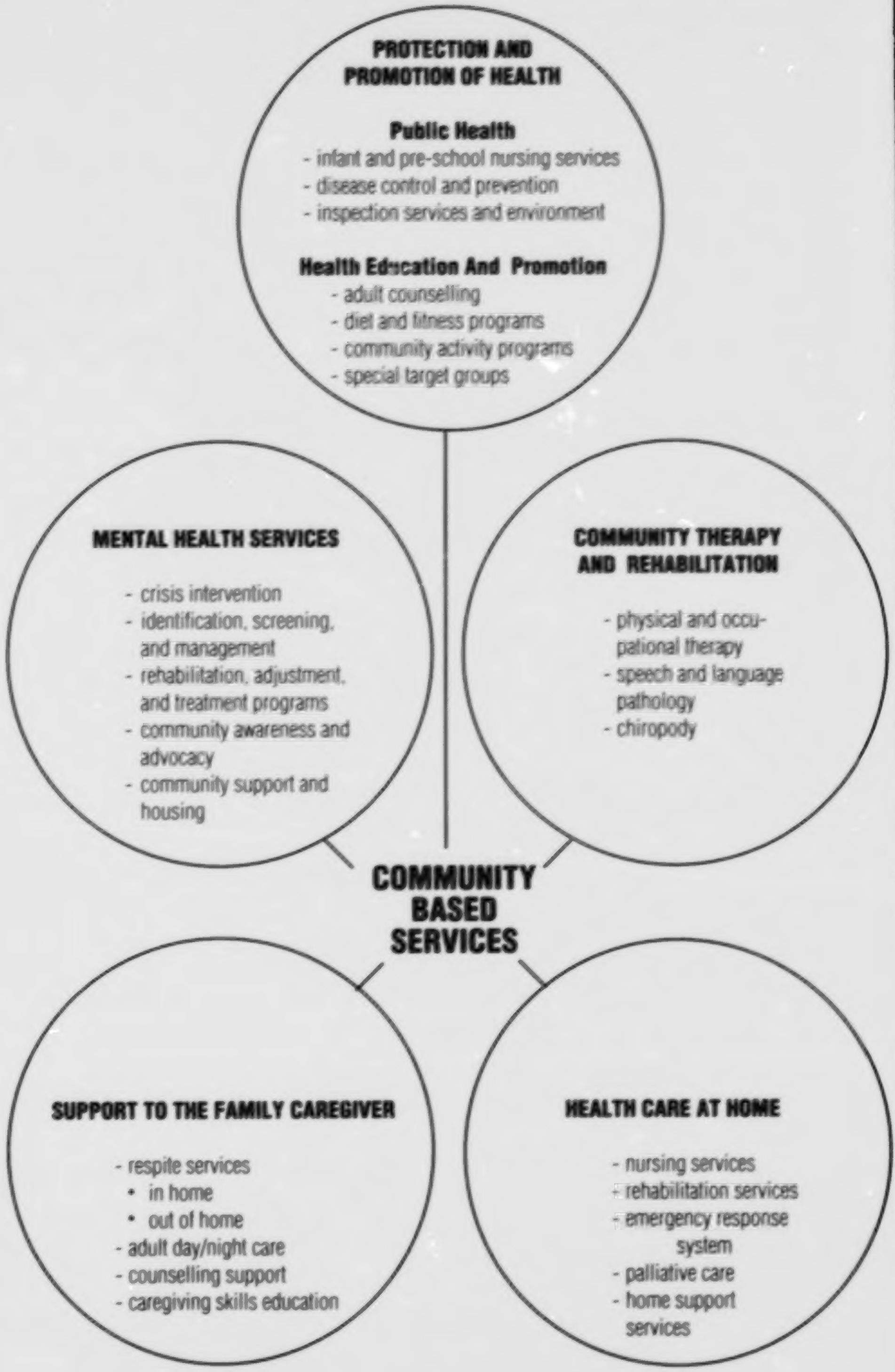
(b) In most instances, the community mental health workers would be residents of the community, with training in a specially designed orientation program focusing on the needs of the mentally ill.

2.46 **In order to revitalize mental health programs in the province, and to ensure adequate services and supports are available to the mentally ill, the provincial government must significantly increase the portion of health funding allocated to mental health.**

(a) Increases in funding must be accompanied by corresponding increases in staffing and community support programs aimed at increasing the availability of services and their accessibility to mental health clients.

(b) As the division councils assume responsibility for mental health services, they must ensure that mental health programming and other community services which provide support to the mentally ill receive equitable funding and resource allocation in relation to other health programs.

Exhibit A:
A Comprehensive and Co-ordinated Community Health Program



COMMUNITY BASED SERVICES

PROTECTION AND PROMOTION OF HEALTH

Public Health
- infant and pre-school nursing services
- disease control and prevention
- inspection services and environment

Health Education And Promotion
- adult counselling
- diet and fitness programs
- community activity programs
- special target groups

MENTAL HEALTH SERVICES
- crisis intervention
- identification, screening, and management
- rehabilitation, adjustment, and treatment programs
- community awareness and advocacy
- community support and housing

COMMUNITY THERAPY AND REHABILITATION
- physical and occupational therapy
- speech and language pathology
- chiropody

SUPPORT TO THE FAMILY CAREGIVER
- respite services
  - in home
  - out of home
- adult day/night care
- counselling support
- caregiving skills education

HEALTH CARE AT HOME
- nursing services
- rehabilitation services
- emergency response system
- palliative care
- home support services

Exhibit B:
Illustrative Health Targets for the Province of Saskatchewan

DISEASE- AND DEATH- ORIENTED

1. Reduce mortality due to breast cancer by 35% by the year 2000.
2. Reduce the suicide attempts rate for teenagers by 25% by the year 2000.
3. Reduce the perinatal mortality rate by 30% by the year 2000.

LIFESTYLE-ORIENTED

1. Reduce smoking onset among teenagers by 30% by the year 2000.
2. Increase the number of ex-smokers in the general population by 50% by the year 2000.
3. Increase physical activity among the 20 years old and over population, so that by the year 2000, 50% of the adult population is exercising for 20 minutes/day, three times/week.
4. Increase the number of adolescent non-users of alcohol by 90% by the year 2000.

Exhibit C:
Home Care Services and Expenditures

	ACTUAL EXPENDITURES	TOTAL SERVICE UNITS PROVIDED*	NUMBER OF CLIENTS
1985-86	19,569,014	1,396,354	19,372
1986-87	23,030,959	1,501,710	20,601
1987-88	22,962,440	1,374,937	19,101
1988-89	23,472,476	1,375,198	18,842

- Home care service units include nursing services, meals, home maintenance, homemaking and supplementary services such as physical and occupational therapy, and social work.

  One unit of nursing, homemaking or home maintenance is equal to an hour of client service. One meal is equal to one unit of service.

Source: Continuing Care Branch, Saskatchewan Department of Health

Exhibit D:
Mental Health Services Branch
Budget History
1949/50 to 1989/90

YEAR	POSITIONS (FTE)	MHSB BUDGET	HEALTH BUDGET	PER CENT OF HEALTH BUDGET
1949/50		$3,551,460	$5,332,520	66.6%
1958/59	1,900+	$8,829,000	$27,166,150	32.5%
1969/70	2,079	$14,049,050	$140,490,500	10.0%
1979/80	843	$20,297,890	$471,303,580	4.3%
1989/90	715	$32,116,800	$1,372,063,000	2.3%

Source: Mental Health Services Branch, Saskatchewan Department of Health

3. New Thrusts for Institutions

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Foreword

Institutions will always be needed in the health care system, even in a new system which puts much greater effort into helping people continue to live as independently as possible in their own homes, despite illness, disability or age.

However, Saskatchewan people use their health care institutions a great deal. As pointed out in the beginning of this report, the province has far more hospital and long-term care beds per capita than the Canadian average, and people are put into those beds at an excessive rate. Yet, in recent years additional beds have been constructed and more are being constructed right now.

Approaches to the treatment of patients - when to admit them, how long they should remain - vary widely from hospital to hospital. Since there are no patient outcome measurements, such variations are almost impossible to explain.

The same kinds of variations occur with admission to long-term care centres. Often people have entered such a centre before they needed that level of care because they had their name on a list and feared to lose the place if they didn't accept it when it was available.

Applying the principles outlined in the first part of this report to institutions - hospitals and long-term care centres - makes it clear how they must change to fit into the new health care system the Commission has designed for the 1990s and the 21st century.

Firstly, they too must be accountable to the people they serve. Often hospitals, especially in the cities, seem to be remote and distant; the average citizen and consumer of their services is often unaware of who has the responsibility, authority and control of them. The Commission believes that all hospitals and long-term care centres in the province should be under the auspices of the elected council of the division in which they are located.

Since it is building a system that is Saskatchewan-wide, as well as locally controlled, the Commission sees the need for a network of different kinds of hospitals across the province. These must have clearly defined and specific mandates, and must co-operate using the newest technology. The large hospitals in the two major cities must band together to form a unified whole, specializing instead of competing, and they must have formal and informal links with smaller hospitals.

In a health care system that is outcomes-oriented, there will be a clear pattern governing when people are admitted to hospital and how long they remain there, depending on their illness. Except in unusual cases, it will be possible to make general predictions about time and treatment required in hospital, thus permitting more careful budgeting for the hospital and easier planning for the patient and his or her family.

In keeping with its principle of quality of life, the Commission insists that hospitals must not fill their beds with elderly people who would prefer to be in their own homes, as happens too often today. Working in co-operation with a strengthened system of community-based services such as home care, hospitals will minister to the ailments that bring people to them, and then send those people home again. There they will receive the kinds of help discussed in Section 2, permitting them the most independence possible.

The principle of continuity of care receives lip service today, but often little more. The Commission believes that principle requires a unified, co-ordinated health system which stretches from the office of the health care team to the palliative care team and permits people to receive exactly the amount and type of service they need at a particular time. Until sickness occurs, the focus must be on health: prevention, healthy lifestyle, exercise, clean environment. When sickness occurs, the focus shifts to treatment and, if possible, cure; then the person can return to his or her family, who will be supported by community-based services. Eventually, some people may have to move to long-term care centres, but this should occur only when family and community-based services cannot together effectively provide what is needed.

This will ensure the system is both affordable - efficient, effective and streamlined - and dedicated to helping people maintain quality of life.

Saskatchewan hospitals and long-term care centres have demonstrated their adaptability to modern developments in the health care field, and will certainly continue to do so. The principle of adaptability requires more than that, however. It requires flexibility in searching for and adopting new ways of approaching old problems, as well as problems yet to come. More attention must be paid, for example, to giving family caregivers respite from their caregiving responsibilities. Only flexibility, innovativeness, adaptability and willingness to think what might once have seemed unthinkable will meet the needs of this province in the next century.

Great changes are demanded of the health care institutions in this province if they are to operate with a greater degree of effectiveness and responsiveness in the next decade and beyond than they have in the past.

The Commission is confident they can adapt to this more focused role, and expects that both the people who work in the institutions and the people they serve will be happier with it.

Acute Care Institutions in a Changed Society

Many presentations were made to the Commission about the roles of the 134 facilities in Saskatchewan which are labelled as hospitals. These came from boards responsible for operating the smallest hospitals as well as boards of those with the largest number of beds and a comprehensive list of services. From the perspectives of these various institutions, proposals were made concerning the kinds of improvements which should be undertaken.

It was particularly interesting to note that in many instances, these proposals suggested a degree of return to the services of the past which did not take into account some wide-ranging changes which have occurred in Saskatchewan, contributing to a need for redefining roles and responsibilities to better suit today's circumstances.

The changes which most profoundly affect the kinds of roles which existing acute care institutions must fulfil in the future include the following:

- the pronounced population shift from rural to urban Saskatchewan resulting in increased pressures on hospitals in the larger centres.
- the age distribution within the population.
- the increasing difficulty in attracting Saskatchewan health care graduates to the province's smaller communities because of a lack of opportunity to use their skills and knowledge to the fullest degree and because of social considerations (a 28-year-old doctor or nurse wants to locate in a community where there are others of similar age and interests with whom social relationships can be established).
- the increased knowledge and sophistication of the consumer, who wants the best technology and specialty, and assurance that a qualified team of professionals is available in case of emergency.
- the increased dependence on business and personal services located in the larger communities which makes travelling to such communities for medical and hospital care more acceptable.
- the increased dependence on specialists in such areas as obstetrics which were once considered the primary responsibility of general practitioners. This has resulted in an increasing number of small hospitals having no deliveries of babies.
- the reduction in the scope of secondary services in regional and large community hospitals, due in considerable part to the fact that patients from smaller communities are increasingly referred directly to Regina or Saskatoon.
- changes in standards associated with medical practice which lead solo practitioners to refer their patients to larger centres, prompted by regulatory changes by the College of Physicians and Surgeons, fear of litigation and the extent of services available.

On the basis of the presentations made to it, as well as its own study and analysis of the situation, the Commission has concluded that major changes must be made in the delivery of hospital services if the interests of Saskatchewan residents are going to be served to the best degree possible.

RECOMMENDATIONS

3.1 The mandates of hospitals in the province must be redefined to reflect the extent of services appropriate in various settings for the immediate and more distant future, and to ensure that roles of facilities of different sizes are complementary.

(a) The redefinition must take into account the current level of services, the potential for expansion, the availability of professional and technological services, the population base served, and use of the facility.

3.2 The examination and redefinition of hospital mandates must result in a classification of acute care facilities which will better serve community needs and ensure the most legitimate and appropriate services are available at various levels.

(a) There should be three classifications, as follows:

(i) Base hospitals
(ii) Division hospitals
(iii) Community hospitals
- community A
- community B

3.3 The three hospitals in Saskatoon and the three hospitals in Regina should be designated as BASE HOSPITALS and should provide specialized expertise and services at the tertiary and quaternary levels for the province as a whole.

(a) In addition to their referral roles, the base hospitals must provide basic hospital services to residents of Regina and Saskatoon and immediate environs.

3.4 The major hospitals within each division should be designated as DIVISION HOSPITALS offering a wide range of secondary services, and serving as the major secondary care referral centres for the divisions in which they are located.

(a) More specialized services would be provided by specialists recognized by the College of Physicians and Surgeons who would have privileges on an itinerant or permanent resident basis.

3.5 Hospitals in the smaller communities in each division which have an average acute care daily census of 40 or less should be designated as COMMUNITY HOSPITALS offering a limited range of basic hospital services.

(a) Hospitals with an average acute care daily census of 20 or more should be designated Community A.

(b) Hospitals with an average acute care daily census of approximately 10 to 19 should be designated Community B.

3.6 The smallest hospitals, with an average acute care daily census of less than 10, should be revitalized into new multi-purpose facilities known as FAMILY HEALTH CARE CENTRES, providing a broad range of primary, outreach, outpatient and other services, in keeping with the changing health circumstances of the local population.

The Mandate of Base Hospitals

Through various studies and presentations, the Commission became aware of the increasing importance attached to the services provided by the six base hospitals in the province. Several factors contribute to this. These include advances in high-cost technology, availability of highly-trained specialists, changed travelling patterns and improved transportation links, and increased consumer sophistication and demand.

It became evident that the dependency on services in the base hospitals would not decrease unless formal links could be established between division hospitals and the combination of base hospitals in each of the large centres, providing for an extension of sophisticated services to division hospitals.

Despite efforts to extend services to division hospitals, the most complex procedures requiring the highest degree of expertise, and dependent on the most sophisticated equipment, will always be the responsibility of base hospitals. Thus it must be recognized that the Regina and Saskatoon hospitals have a special responsibility to serve the total population of the province.

Furthermore, consideration of these factors and responsibilities makes it evident that the manner in which the base hospitals in the two cities operate has to change.

To adequately provide medical services which depend on very costly sophisticated technology, highly-trained specialists and sub-specialists, and intricate and advanced support systems, each individual base hospital of tomorrow must be given exclusive responsibility for specific services Only through such rationalization and the development of "centres of excellence" will it be possible to acquire the services of specialists, obtain the most advanced technology, and ensure our major hospitals remain the equals of health centres outside the province. The six base hospitals in the two cities can no longer all be general hospitals.

RECOMMENDATIONS

3.7 In order to occupy a position of regard and respect and to provide leadership and innovation in developing and improving health services, the three base hospitals in each of Saskatoon and Regina must articulate a unified and complementary mandate which clearly defines areas of medical and administrative expertise and co-ordination.

(a) Without necessarily affecting the ownership of the hospitals, mechanisms must be found to move toward the co-ordination reflected in the concept of "a Saskatoon Hospital Complex" and "a Regina Hospital Complex".

3.8 The combined mandate of the three base hospitals in each centre must reflect their special responsibility to the total patient population in the province to provide diagnosis and treatment which cannot realistically be provided in division or community hospitals.

(a) Base hospitals must also provide a wide range of secondary services for the people living within the two cities and their immediate vicinities.

3.9 Rural division councils and the Regina and Saskatoon division councils must develop formal agreements for the base hospitals to share expertise with and extend services to the division hospitals so their roles can be enhanced, resulting in more people obtaining specialized services closer to home.

(a) Two possibilities for formal twinning which should be investigated are itinerant specialty visits and diagnostic support through sophisticated communications technology.

3.10 The Regina and Saskatoon division councils should pursue joint ventures among their respective base hospitals as future services, programs and policies for the delivery of acute care services are developed.

(a) Joint ventures could include medical transportation and the establishment of hostel units as an alternative to hospitalization for people from outside the city who have been referred for diagnosis, treatment or day surgery.

3.11 **The division councils responsible for the base hospitals must enter into formal affiliation agreements with the health science faculties at the University of Saskatchewan and the Saskatchewan Institute of Applied Science and Technology for the purpose of developing educational and research initiatives involving all the base hospitals.**

(a) Such formal agreements should provide an opportunity for undergraduate and postgraduate experience in selected specialty areas existing in each of these hospitals.

3.12 **Based upon the defined roles for each base hospital and the specialized services within each, the division councils in Saskatoon and Regina must develop joint formal medical manpower plans which underlie efforts to recruit specialists and subspecialists, and determine hospital admitting privileges.**

(a) A medical manpower plan should generally take into account epidemiological and demographic trends, identifiable health needs of the provincial population, and the development of hospital services in the longer term.

3.13 **Division councils must examine the relationship between general practitioners and base hospitals, particularly in terms of the privileges of general practitioners in the expanding secondary and tertiary roles of these hospitals, and the increasing number of practices being established in the base cities, with a view to determining the appropriate number of privileges granted.**

(a) Policies should be developed to provide guidelines for determining the number of general practitioner privileges appropriate to each base hospital.

The Mandate of Division Hospitals

Seven hospitals in the province are currently designated as regional hospitals and seven others are designated as large community hospitals. These differences in designation were made on the basis that the former offered a more extensive list of services. This is not necessarily the case any longer and the distinctions which once prevailed, justifying the differences in designation, do not exist in the same degree today.

It has been drawn to the Commission's attention that, in some instances, large community hospitals which normally have a smaller rated bed capacity than the regional hospitals have been able to expand their services to exceed those of the latter. To a considerable degree, these developments reflect imaginative initiatives by local boards, management staffs and health care professionals.

It is also to be noted that the regional hospitals which are supposed to provide the wider spectrum of services are not equally distributed throughout the province. The large northeast and southeast areas have no regional hospitals. However, they do have large community hospitals which, in certain instances, perform comparable roles.

Various briefs have also indicated to the Commission that it would be desirable to expand the services that are available close to the rural residents of Saskatchewan.

The establishment of health services divisions and division councils would suggest a new potential exists for the development of expanded division hospital services.

RECOMMENDATIONS

3.14 The designation of division hospital should be adopted with a mandate to make available to residents of rural divisions a reasonable range of secondary hospital services, so they have ready access to such care with a minimum of travel.

(a) The range of services provided by medical specialists recognized by the College of Physicians and Surgeons could include general surgery, anaesthesia, pathology, radiology, internal medicine and obstetrics.

3.15 In all divisions, certain acute care facilities which realistically can provide the approved range of secondary services should be designated as division hospitals, and serve residents as the major referral centres for these services.

(a) In some divisions, it would be appropriate to designate certain hospitals as co-division hospitals which share responsibility for secondary hospital services.

(b) Each of the proposed Northern Saskatchewan divisions should have a designated division hospital offering a broader range of services than those in rural divisions in southern Saskatchewan. (Refer to Recommendation 6.10)

3.16 Rural division councils should develop formal agreements with the College of Medicine for residency training in their designated division hospitals to ensure that the College has a presence in institutions outside the two largest urban centres.

(a) The residency training might be most appropriate in areas such as family practice, general surgery, internal medicine and obstetrics, provided that medical staff with teaching expertise are available. (Refer to Recommendation 4.23).

3.17 Each division council with a designated division hospital must have a formal medical manpower plan which is related to the hospital's mandate and the total hospital services provided within the division.

(a) The manpower plan should be directed at enhancing the role of the division hospital as a referral centre and ensuring continuity and stability of service.

(b) The plan should provide for specialist services extended from the base hospital centres according to a formal agreement.

(c) The plan should also provide for the granting of privileges in a division hospital to physicians practising in the smaller community hospitals in the areas it serves.

3.18 Rural division councils must develop and adopt pro-active plans for recruiting suitably qualified physicians to practise in the communities where division and co-division hospitals are located.

(a) Medical practitioners located in division hospital centres must develop policies and practices designed to attract specialist colleagues to complement their practices.

The Mandate of Community Hospitals and Family Health Care Centres

The Commission is keenly aware of the changing face of rural Saskatchewan and the impact of that change on the future role of the community hospital. The time has come to strike out with bold, new initiatives for rural health facilities. Numerous considerations have caused the Commission to take this stand. These include:

- More and more rural people are receiving hospital and medical services in Regina and Saskatoon rather than their local community.
- The population of rural Saskatchewan is declining in absolute numbers.
- The population of rural Saskatchewan is aging rapidly and the geriatric care needs of people living in smaller towns and villages present a special challenge.
- Saskatchewan has an over-abundance of acute care hospital beds in its rural areas; it has the highest ratio of beds per 1,000 population in Canada.

- These acute care beds are scattered in numerous small hospitals which results in Saskatchewan having more hospitals than any province except Ontario.

- Some of these small hospitals may be having difficulty meeting modern care standards; Saskatchewan has the smallest percentage of accredited hospitals in Canada.

- Rural hospitals are finding it increasingly difficult to recruit physicians into solo practices and basically impossible to recruit Canadian medical graduates into such practice settings.

Rural hospital trustees increasingly recognize that old approaches to providing rural health care are no longer viable and that new mandates and kinds of delivery are essential if people in rural Saskatchewan are to continue to have ready access to needed health care services. It is not evident to the Commission that the integrated facility is the only alternative or that such facilities have always been constructed with due regard to legitimate long-range needs.

It is clear that some rural hospital services should be consolidated in the interests of quality care and sound economics.

New communications technologies offer tremendous potential in assisting rural health care providers to overcome the challenge of geography.

RECOMMENDATIONS

3.19 A province-wide plan for rationalizing services in hospitals with an average acute care daily census of 40 or less must be developed and uniformly adopted throughout Saskatchewan, taking into account the appropriate range of acute care services, the population served, current utilization patterns, and the availability of professional staff.

(a) All hospitals with an average acute care daily census of 20 or more should be put in the proposed community A designation.

(b) All hospitals with an average acute care daily census of 10 to 19 should be put in the proposed community B designation.

(c) The mandates of all hospitals with an average acute care daily census of nine or less should be redefined to more adequately serve the population mix in their areas, and they should be designated family health care centres.

3.20 Those hospitals designated community A should be able to provide such services as basic radiology and laboratory testing, limited

medical and surgical services (general medicine, geriatrics, uncomplicated obstetrics), and primary emergency care.

(a) The criteria for community A designation should include accreditation by the Canadian Council on Health Facilities and a medical staff of at least three fully-qualified physicians.

(b) Physicians resident in neighboring communities should be granted privileges in these hospitals.

3.21 **Community B hospitals should offer services similar to those of the larger community A hospitals, but with greater limits on obstetrical and surgical services.**

(a) The criteria for the designation of community B hospitals should include accreditation by the Canadian Council on Health Facilities and a strong preference for a medical staff consisting of at least two physicians.

(b) To meet the medical staff criterion, privileges should be granted to physicians resident in neighboring communities.

3.22 **The Department of Health and division councils should together develop plans for revitalizing the smallest hospitals (average acute care daily census of nine or less) into family health care centres, creating a provincial network which offers a broad range of primary health services throughout rural Saskatchewan.**

(a) The family health care centres should be headed by primary care nurses and should not be dependent upon doctors being resident within the community, but could have regularly scheduled visits by medical personnel.

(b) The core services offered at each family health care centre would fall into three major categories:

(i) Basic nursing services - emergency, home support, public health, mental health.
(ii) Visiting health professionals - physicians, psychiatrists, psychologists and other mental health professionals, physical therapists, speech and language pathologists/audiologists, occupational therapists, dietitians/nutritionists, chiropodists.
(iii) Health education and fitness - well-baby clinics, well-seniors clinics, blood pressure clinics, health counselling services.

3.23 **Each division council should designate two or three family health care centres as COMPREHENSIVE FAMILY HEALTH CARE CENTRES**

offering a more extensive program, selected on the basis of the population served, the proportion of seniors in the population, and convenience of location.

(a) Wherever integrated facilities exist, these should be designated as comprehensive family health care centres.

(b) In addition to the core services, the comprehensive family health care centres could provide expanded services for seniors, such as respite care beds, adult day and night care and temporary residential care, including temporary accommodation within the facility of people needing minimal acute care after hospitalization or for other specified purposes.

(c) The mandate of the comprehensive family health care centre could include providing shelters for battered women or abused children.

3.24 A sophisticated communications network should be developed by the Department of Health, in partnership with the division councils, and funded by the Department, to provide modern communications technologies to community hospitals and family health care centres so that consultation and advice from the larger centres can be made readily accessible to all facilities across the province.

(a) A basic communications network linking these institutions of differing size and mandate should include fax machines, ultrasound and radiographic equipment, cellular telephone equipment and other up-to-date technology as it becomes available.

Managing the Utilization of Hospital Services

Hospital boards and public officials are constantly being challenged about the assurance of quality patient care and the management of hospital utilization.

Most American hospitals and some Canadian hospitals have undertaken specific management initiatives to address these critical concerns. These initiatives are commonly referred to as "utilization management", which can be defined as an organized and systematic methodology by which boards and administrators can inspire attending physicians to increase the efficiency and effectiveness of the hospital care process.

In simple terms, utilization management involves the establishment of explicit criteria for the admission, treatment, and discharge of patients, and a monitoring system. It can be prospective (before admission), concurrent (after admission but before discharge) or retrospective (after discharge) in nature.

Retrospective utilization management is the system practised most often by Canadian hospitals. Data-gathering systems are put in place to measure a patient's severity of illness and essential care level. The medical record is the primary data source. A relatively complex set of predetermined "decision rules" is then applied to the patient to determine the appropriateness of care he or she received. These "instruments" are usually administered by non-physicians with recourse to physician consultants in ambiguous cases.

The attending physician's traditional prerogative to admit, test, treat and discharge individual patients in a relatively unstructured and unquestioned manner is affected by the utilization management approach. Considerable logistical demands are placed on the organization for the implementation and ongoing surveillance of the utilization management initiative, but it also offers opportunities for improvements in care quality and cost savings.

A number of factors seem to indicate the time has come for Saskatchewan hospitals to accept a greater responsibility for the appropriateness of patient admissions and discharges.

A recent government study into the growth and use of health services raised questions about the extent and appropriateness of inpatient care in Saskatchewan hospitals compared to the larger Canadian experience. Many people receiving treatment as inpatients would be outpatients in other provinces, with special reference to the extensive day surgery programs in Alberta. A variety of factors indicate that many hospital beds are occupied by patients who do not need to be there.

The lengthy nature of surgical waiting lists continues to be a problem for some hospitals, especially those in Saskatoon.

The public expects that high quality and appropriate hospital treatment will be received as required and objects to spending two or three days in an emergency department because inpatient beds are unavailable.

The Commission established a hospital utilization management systems study committee to examine the possibility of increasing the effective utilization of hospital facilities. This committee visited 25 Saskatchewan hospitals and met with a number of individuals involved in delivering hospital services in this province and beyond. It found a general willingness to undertake new utilization management initiatives.

RECOMMENDATIONS

3.25 A province-wide system must be developed to manage hospital utilization, taking into account standardized admission criteria for all acute care services, and it must form the basis for policies and practices of division councils.

(a) All elective admissions must be closely monitored to ensure they conform with criteria which justify admission.

(b) After admission, a standardized care protocol must be followed to ensure high quality and timely care practices.

3.26 A PROVINCIAL HOSPITAL UTILIZATION MANAGEMENT COMMITTEE must be established to develop appropriate criteria for all categories of hospitals, monitor these and propose revisions as appropriate to changing practices and advancing technologies and specialties.

(a) The provincial hospital utilization management committee should consist of two nominees from each of the College of Physicians and Surgeons, the Saskatchewan Registered Nurses' Association, the Saskatchewan Association of Health Services Executives, and the Division Council Co-ordinating Board. It would select one of its members to serve as a chairperson.

(b) The provincial hospital utilization management committee should request the College of Physicians and Surgeons to prepare a set of medical practice protocols which would form the basis of hospital utilization policies.

(c) The provincial hospital utilization management committee should be responsible for an ongoing review of utilization practices and policies and should submit its evaluations and proposals for any modifications in an annual report to the Department of Health, division councils and the Health Analysis and Development Commission.

3.27 In determining the hospital component of each division council's budget, the Department of Health must implement funding policies which ensure that every hospital fulfils its acute care mandate to the greatest extent possible.

(a) Such policies must recognize the measurement of intensity of service required, average length of stay and case mix.

3.28 Each division council must require the establishment of a UTILIZATION MANAGEMENT COMMITTEE for its division, community and base hospitals, which will develop policies to ensure the most effective utilization of acute care facilities, and monitor the application of those policies.

(a) Each division and base hospital should establish an institution committee consisting of representatives of the medical staff, nursing staff, auxiliary staff and administration.

(b) For all community A and community B hospitals within a division, a single division utilization management committee should be established, consisting of the chairperson of a division hospital utilization management committee, and one representative of the medical staffs, the directors of nursing and the hospital administrations.

Long-Term Institutional Care

In its analysis of the need for long-term institutional care, the Commission became aware of the fact that Saskatchewan has a high ratio of long-term care beds to population. Its attention was also drawn to the fact that there has been a tendency in the last few years to construct even more long-term care facilities.

Examples were presented of difficulties encountered by operators of some rural heavy care facilities in finding sufficient residents requiring heavy care to occupy the facilities. As a result, in a significant number of instances, Level I and II residents occupy facilities designated for Level III and IV use. However, this is not the case in certain areas of the province where the ratio falls below the provincial average and where additional beds are still required.

Despite the generous allocation of long-term care beds in the province, several presentations to the Commission expressed concern about an inability to place cognitively impaired or emotionally unstable people in an appropriate institutional setting.

It has been suggested that the presence of people with behaviorial problems would be upsetting to other residents, and that a number of facilities are inappropriately staffed to accommodate the special needs of this group.

Presenters, particularly those representing seniors' organizations, suggested to the Commission that the dominant attitude today is to avoid and resist institutionalization. Independent supportive living services must become the alternative to placement in long-term care centres.

It became evident that a much more systematic approach must be found for the provision of long-term care services in the province. It is particularly essential that there be a detailed, uniform system for assessing the needs for varying degrees of institutional care. What is also needed is a system such as Medicus or the Nursing Information System of Saskatchewan (NISS) which would determine the staffing levels and mixes required to ensure those levels of care can be provided.

RECOMMENDATIONS

3.29 Using provincially-adopted standards and objectives, each division council must develop a clearly-defined plan for providing services, programs and facilities required by residents designated as needing heavy long-term care.

(a) The division plan must take into account the heavy care needs of seniors with severe physical incapacities, younger members of society with serious physical disability, and the elderly with cognitive impairment.

3.30 All institutions whose primary purpose is providing services at Levels III and IV should be designated as SUPPORTIVE CARE CENTRES.

(a) All supportive care centres must have a rated bed capacity for Levels III and IV of at least 30 and must meet accreditation standards established by the Canadian Council on Health Facilities Accreditation.

3.31 The global budget of each division council should include an allocation from the Department of Health for Levels III and IV institutional care on the basis of a ratio of 160 beds per 1,000 people aged 75 and over.

(a) The ratio of 160 per 1,000 should include 25 beds for the severely cognitively impaired.

3.32 The severely cognitively impaired should be accommodated in residential units for five to seven people which should be located in a neighborhood residence or a specially-designed residential suite in an existing health care facility.

(a) The program should emphasize supportive interpersonal relationships and compassionate care in a low-stress environment.

3.33 The present integrated facilities should be designated as comprehensive family health care centres which would continue to provide accommodation for Levels III and IV residents and would develop outreach programs, including adult day/night care and respite care.

(a) The level of funding should be determined by the actual number of Levels III and IV residents, as well as the components of the expanded outreach program.

3.34 A detailed uniform classification system which clearly identifies the level and extent of care required by each resident in a supportive care centre, and a workload monitoring system, must be developed by the Department of Health for adoption by division councils as the basis for admitting residents, determining service levels and establishing staffing guidelines.

(a) Residents should be admitted to a supportive care centre only after assessment by division council personnel using the provincially-adopted classification system, and recognizing that community supportive living systems are no longer able to meet their needs.

3.35 Provincial authorities must proclaim and division councils must enforce regulations governing personal care homes to ensure they provide quality care and safe and comfortable surroundings for the residents.

(a) To ensure that operators of personal care homes have a knowledge of the physical and emotional supports that residents require, division councils should provide related orientation seminars and short courses.

Management of Health Care Institutions

The Commission believes that even when they are owned by a division council, larger hospitals and supportive care centres should have management boards.

Several factors caused it to reach this conclusion.

Saskatchewan is a large province with a high degree of community spirit. It is important that local citizens be afforded an opportunity for input into the day-to-day management of local institutions.

Lay boards can be very helpful in offering guidance to administrators and care providers.

Saskatchewan has a proud tradition of volunteer trusteeship which should be respected.

The Canadian health care industry has recently experienced isolated cases of financial malfeasance by health system administrators. Lay board supervision helps to support and preserve the integrity of the industry.

RECOMMENDATIONS

3.36 Division councils must establish management committees for all larger health care institutions and for a combination of smaller ones, with representation from local citizens as well as health professionals.

(a) Each management committee selected by the division council should consist of seven to nine members representing residents of the areas served by the facility, and one representative from each of the medical and nursing professions.

(b) The management committee should be charged with responsibility for the day-to-day operation of the facility it represents, in accordance with the policies and priorities of the division council.

(c) In the smaller communities, a management committee should have responsibility for a combination of acute care and long-term care facilities.

3.37 All hospitals and supportive care centres privately owned by religious or corporate agencies should continue their existing arrangements for the day-to-day management of their facilities, including appointment of their own boards of trustees and executive personnel.

(a) Such boards of trustees would have day-to-day responsibility for ensuring the mandate of the institution they represent is carried out in accordance with agreements and understandings with the division council.

Medical Transportation Services

The Commission heard many concerns about ambulance services in Saskatchewan. Specifically, lack of co-ordination, inconsistencies in staffing, duplication of services, and lack of protocols were identified most frequently as issues requiring attention.

It was suggested to the Commission that, in order to keep pace with advancing technology and the consumer's increased expectations, the ambulance system must be upgraded to ensure that the highest level of emergency treatment is available in a consistent manner.

To a considerable extent, these concerns and expectations were reflected in the brief presented by the Saskatchewan Health-Care Association:

> *"While many individual ambulance services already deserve the designation of 'first class', the system as a whole does not. This is because there is no interlocking structure that ensures equity or consistency on a province-wide scale."*

Other problems identified which require consideration include the following:

There is insufficient linkage between hospitals and ambulances which detracts from the fact that ambulances serve a health care purpose.

The number of appropriately trained personnel varies considerably from one region to another, contributing to inequity in the level of support services available.

Ambulance services are managed by 108 ambulance boards which frequently operate independently of other health care boards.

There is a wide variation in user charges from one area of the province to another, frequently resulting in those residents farthest from larger centres having to pay much more than those closer.

There is lack of centralized dispatching, which frequently results in an overlapping of services and under-utilization of equipment.

The Commission concluded that major restructuring of ambulance services must be undertaken to provide for better co-ordination and to ensure the highest standards of service are provided in keeping with the advancements of medical technology and knowledge.

RECOMMENDATIONS

3.38 A comprehensive and co-ordinated medical transportation system must be developed by the Department of Health, ensuring that a wide range of quality and cost-effective emergency and non-emergency transportation is available in an equitable manner throughout Saskatchewan.

(a) Taking into account Saskatchewan's geography, the plan must provide for rationalization of air ambulance, advanced road ambulance, primary road ambulance and auxiliary transportation services (those not requiring sophisticated equipment).

3.39 Each rural division council should be responsible for delivery of a co-ordinated and interlocking network of road ambulance and auxiliary transportation services within its division.

(a) The medical transportation services in each division should have their headquarters at a division hospital which must ensure that advanced road ambulances with a mix of appropriately-trained emergency medical personnel and properly-equipped vehicles are always available to provide the best service in life-threatening situations.

(b) Divisions with co-division hospitals should select the most central location as the headquarters for the medical transportation service.

(c) Centres with small acute care facilities should be designated as satellite stations offering a primary road ambulance service which can be provided by part-time and volunteer staff trained in basic emergency care, preferably at the EMT level, and operating less sophisticated equipment.

(d) In most instances, primary road ambulances would transport their patients to satellite stations or the closest division centre.

3.40 In Saskatoon and Regina, the division councils should establish MEDICAL TRANSPORTATION COMMITTEES responsible for providing a co-ordinated and integrated program of ambulance and auxiliary transportation services for the three hospitals in each city.

(a) The medical transportation committees in Saskatoon and Regina should provide services to the Saskatoon and Regina rural divisions respectively.

(b) One of the base hospitals in each city should be designated as the medical transportation services headquarters for the division.

3.41 A division dispatching unit should be located in each hospital designated as headquarters for a division's medical transportation services.

(a) In Regina and Saskatoon, the base hospitals designated as the headquarters hospital for the service should assume responsibility for the dispatching system within the city and the rural division surrounding it.

3.42 A SASKATCHEWAN MEDICAL TRANSPORTATION AUTHORITY should be created to administer and operate the provincial air ambulance service and to develop and establish inter-divisional communications and dispatching links.

(a) The Saskatchewan Medical Transportation Authority should consist of seven members, with four representing division councils (including one from the North), one representing the College of Physicians and Surgeons, one representing the Saskatchewan Registered Nurses' Association and one representing the Saskatchewan Ambulance Association.

(b) A northern branch of the authority should be located in La Ronge in order to provide air ambulance and communication services specifically designed for Northern Saskatchewan. (See Section 6).

(c) The Saskatchewan Medical Transportation Authority should undertake to explore the possibilities and potential of a central response system for the province.

3.43 **The Department of Health should establish a standard pickup and mileage fee for each level of medical transportation, capping ambulance charges regardless of distance, mode of transportation or patient age, to ensure consistency and equity in user charges among the divisions.**

(a) The Saskatchewan Medical Transportation Authority should be consulted about any modifications in policies governing ambulance charges.

Exhibit A:
Saskatchewan Hospitals
in Operation
as of December 31, 1989

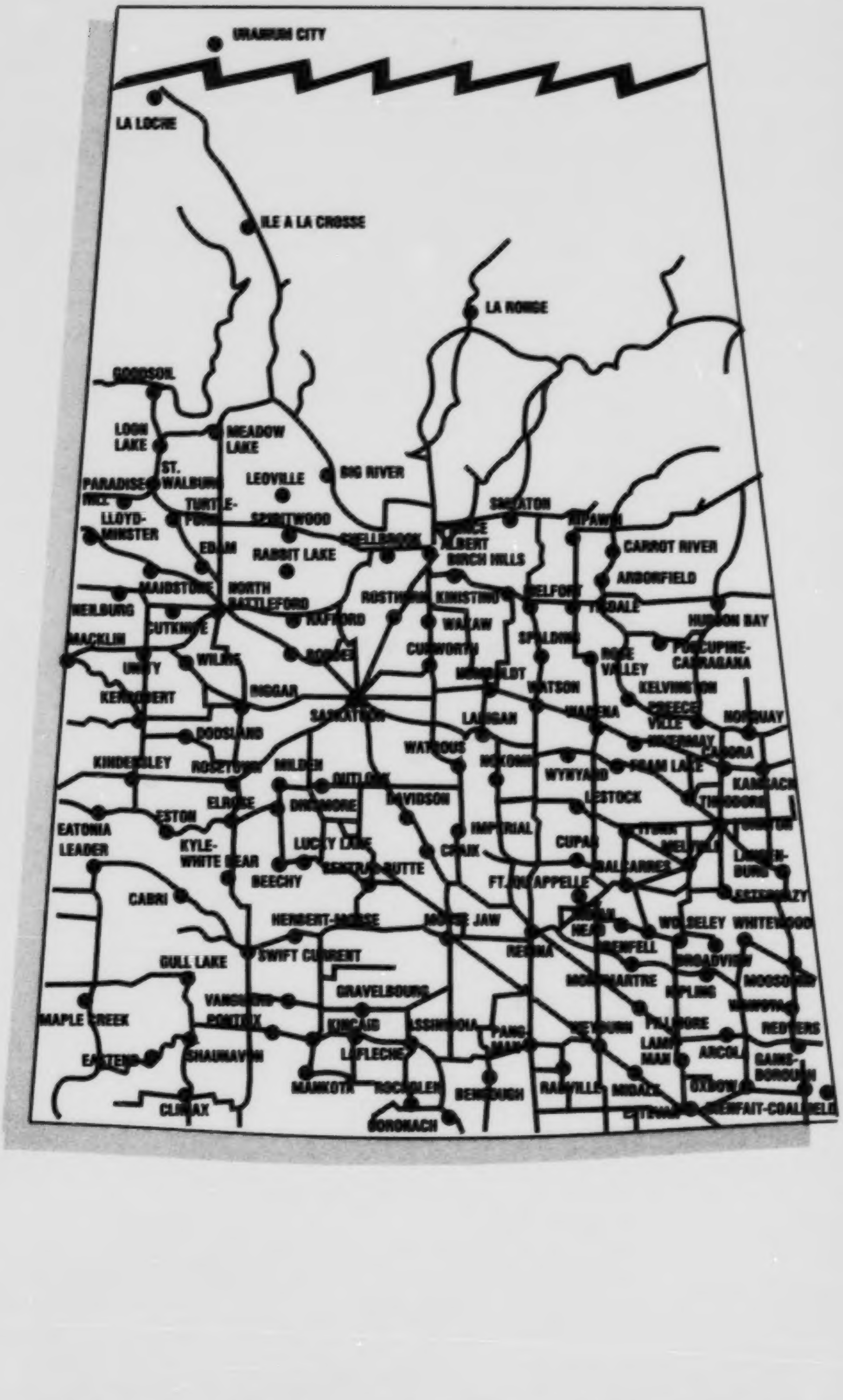

URANIUM CITY
LA LOCHE
ILE A LA CROSSE
LA RONGE
GOODSOIL
LOON LAKE
MEADOW LAKE
ST. WALBURG
PARADISE HILL
LEOVILLE
BIG RIVER
TURTLEFORD
LLOYDMINSTER
SPIRITWOOD
SMEATON
NIPAWIN
EDAM
SHELLBROOK
PRINCE ALBERT
CARROT RIVER
RABBIT LAKE
BIRCH HILLS
ARBORFIELD
MAIDSTONE
NORTH BATTLEFORD
NEILBURG
ROSTHERN
KINISTINO
MELFORT
TISDALE
HUDSON BAY
CUT KNIFE
HAFFORD
WAKAW
MACKLIN
SPALDING
ROSE VALLEY
PORCUPINE-CARRAGANA
UNITY
WILKIE
BORDEN
CUDWORTH
HUMBOLDT
WATSON
KELVINGTON
KERROBERT
BIGGAR
SASKATOON
LANIGAN
WADENA
PREECEVILLE
NORQUAY
DODSLAND
INVERMAY
CANORA
WATROUS
NOKOMIS
WYNYARD
FOAM LAKE
KINDERSLEY
ROSETOWN
MILDEN
OUTLOOK
LESTOCK
KAMSACK
ELROSE
DINSMORE
DAVIDSON
THEODORE
EATONIA
ESTON
IMPERIAL
ITUNA
YORKTON
MELVILLE
LEADER
KYLE-WHITE BEAR
LUCKY LAKE
CRAIK
CUPAR
CENTRAL BUTTE
BALCARRES
LANGENBURG
BEECHY
FT. QU'APPELLE
ESTERHAZY
CABRI
INDIAN HEAD
WOLSELEY
WHITEWOOD
HERBERT-MORSE
MOOSE JAW
GRENFELL
REGINA
BROADVIEW
GULL LAKE
SWIFT CURRENT
MONTMARTRE
KIPLING
MOOSOMIN
GRAVELBOURG
VANGUARD
WAWOTA
PONTEIX
FILLMORE
REDVERS
MAPLE CREEK
KINCAID
ASSINIBOIA
PANGMAN
WEYBURN
LAMPMAN
ARCOLA
GAINSBOROUGH
EASTEND
SHAUNAVON
LAFLECHE
MANKOTA
ROCKGLEN
BENGOUGH
RADVILLE
MIDALE
OXBOW
ESTEVAN
BIENFAIT-COALFIELDS
CLIMAX
CORONACH

Exhibit B: Occupancy of Hospitals in Saskatchewan by Size Category March 31, 1989

SIZE CATEGORY	TOTAL NUMBER OF HOSPITALS	HOSPITAL BEDS	AVERAGE DAILY OCCUPANCY	PER CENT OCCUPANCY
Under 50 Beds	107	2177	1348	62%
50-99 Beds	10	652	423	65%
100-299 Beds	9	1482	1055	71%
300 or more Beds	7	2934	2341	80%
* ALL HOSPITALS	133	7245	5187	71%

* Does not include Wascana Rehabilitation Centre.

Note: Occupancy includes acute care and long-term care patients.

Source: Hospital Services Branch, Saskatchewan Department of Health.

Exhibit C:
Hospitals -
Provinces and Canada
March 31, 1988

		Beds Per 1,000 Population		Separations Per 1,000 Population	
	Number of Hospitals	Rank	Beds	Rank	Separations
Canada	892		5.1		137.7
Saskatchewan	133	1	6.9	1	206.9
British Columbia	105	3	5.9	8	143.2
Alberta	122	4	5.7	4	168.7
Manitoba	81	5	5.6	6	153.7
Ontario	200	10	4.6	9	137.6
Quebec	129	9	4.8	10	103.9
New Brunswick	32	2	6.1	3	170.9
Nova Scotia	48	5	5.6	5	154.1
Prince Edward Island	7	7	5.4	2	194.5
Newfoundland	35	8	5.1	7	148.1

Note: Separation is an indication of the people who have been hospitalized. It includes those who are discharged from hospital, transferred to another health care facility or who die in hospital.

Sources: Statistics Canada; Hospital Services Branch, Saskatchewan Department of Health. The Saskatchewan figure does not include the Wascana Rehabilitation Centre.

Exhibit D:
Complement of Long-Term Care Beds in the Provinces 1989

PROVINCE	NUMBER OF[1] BEDS	POPULATION[2] OVER 75	BEDS/1000 OVER 75
Newfoundland	2,526	20,400	124
Prince Edward Island	1,180	7,400	159
Nova Scotia	5,964	45,300	132
New Brunswick	6,419	35,100	183
Quebec	47,553	275,800	172
Ontario	70,263	438,100	160
Manitoba	8,901	60,500	147
Saskatchewan	10,025	58,500	171
Alberta	14,143	85,900	165
British Columbia	25,717	157,900	163
CANADA	192,691	1,184,900	163

Note: The above table excludes psychiatric beds and includes long-term care beds in acute care facilities. Because the definition of long-term care beds varies between provinces, the figures shown must be considered as estimates only.

Sources:

1. Directory of Long-Term Care Centres in Canada, 1989 and Canadian Hospital Directory, 1989-90, Canadian Hospital Association, Ottawa
2. Statistics Canada, Post Censul Annual Estimates of Population by Marital Status, Age, Sex and Comparison of Growth for Canada, Provinces and Territories, 1989 (catalogue #91-210)

Exhibit E:
Distribution of Long-Term Care Residents by Sex and Marital Status March 31, 1988

MARITAL STATUS	**LONG-TERM CARE RESIDENTS**					
	MALE		**FEMALE**		**ALL**	
	NUMBER	**PER CENT**	**NUMBER**	**PER CENT**	**NUMBER**	**PER CENT**
Single	1,075	31.8	749	11.3	1,824	18.2
Married	1,094	32.4	804	12.1	1,898	18.9
Widowed	989	29.3	4,871	73.3	5,860	58.5
Divorced/Separated	186	5.5	167	2.5	353	3.5
Other	33	1.0	56	0.8	89	0.9
Total	3,377	100.0	6,647	100.0	10,024	100.0

Source: Saskatchewan Department of Health Annual Report for the year ending March 31, 1988.

Exhibit F:
Long-Term Care Residents as a Percentage of Provincial Population by Age and Sex March 31, 1988

AGE GROUP	**MALES**			**FEMALES**			**ALL**		
	Residents	Population	Utilization Rate	Residents	Population	Utilization Rate	Residents	Population	Utilization Rate
	Number	Number	%	Number	Number	%	Number	Number	%
0-19	5	170,076	0.0	4	162,246	0.0	9	332,322	0.0
20-39	91	176,780	0.1	70	167,955	0.0	161	344,735	0.0
40-59	197	96,962	0.2	197	94,805	0.2	394	191,767	0.2
60-64	113	21,737	0.5	123	22,781	0.5	236	44,518	0.5
65-69	179	19,540	0.9	224	21,799	1.0	403	41,339	1.0
70-74	327	16,409	2.0	436	19,186	2.3	763	35,595	2.1
75-79	485	11,578	4.2	776	14,218	5.5	1,261	25,796	4.9
80-84	669	6,945	9.6	1,375	9,437	14.6	2,044	16,382	12.5
85-89	682	3,342	20.4	1,635	5,051	32.4	2,317	8,393	27.6
90-94	418	1,158	36.1	1,221	2,271	53.8	1,639	3,429	47.8
95+	211	384	54.9	586	780	75.1	797	1,164	68.5
Total	3,377	524,911	0.6	6,647	520,529	1.3	10,024	1,045,440	1.0

Source: Saskatchewan Department of Health Annual Report for the year ending March 31, 1988.

Exhibit G:
Accreditation of Health
Facilities in Saskatchewan

ACCREDITATION OF HOSPITALS

1988

SIZE CATEGORY	Number of Hospitals	Number Accredited	Per cent Accredited
Under 50 Beds	107	26	25%
50-99 Beds	10	10	100%
100-299 Beds	10	10 *	100%
300+ Beds	7	7	100%
ALL HOSPITALS	**134 ***	**53**	**40%**

* Includes Wascana Rehabilitation Centre

ACCREDITATION OF LONG-TERM CARE FACILITIES

1988

SIZE CATEGORY	Number of Facilities	Number Accredited	Per cent Accredited
Under 50 Beds	93	5	5%
50-99 Beds	39	4	10%
100-299 Beds	23	9	39%
300+ Beds	4	2	50%
ALL FACILITIES	**159**	**20**	**13%**

Source: Canadian Council on Health Facilities Accreditation, 1988
Saskatchewan Hospital Services Plan Annual Report 1987-88

4. New Approaches for the Health Professions

Foreword

Physician Services and Practices

Physician Supply and Distribution

Physician Reimbursement Systems

Physician Education Programs

Nursing Roles in the Future

Nurses' Expanded Responsibilities

Nursing Education

Psychiatric Nursing Services

Independent Health Professions

Allied Health Professions

Ancillary Health Professions

Continuing Education for Health Professionals

Exhibits

Foreword

Planning a new health care system, putting together a fine package of community-based services, revamping the kinds of institutions that offer acute and long-term care - these are bold steps toward a different kind of health care future. However, they are nothing without all the professional people who provide all the different kinds of services. The system needs their knowledge, expertise and training; it cannot function unless professionals with such backgrounds have a prominent and effective role. It is not a building or a program or a council that comes to mind when people think of health care; it is Florence Nightingale, or Jonas Salk, or the family's long-time physician, or the therapist who guided their first steps after a serious accident.

Talking with the members of the various health care professions in the province and with the people who use their professional services, the Commission became firmly convinced that it is crucial for these professions to work as members of a team. It is not possible for physicians to meet all the needs of every patient. They must recognize the contribution that can be made by all the other health partners - nurses, physical therapists, occupational therapists, psychologists, chiropractors, pharmacists, and nutritionists.

As medical knowledge doubles every seven years, as scientific theory weds technology to provide new assistance, as researchers learn more about the mind and the body, practitioners of all professions are forced to specialize more and more. Only when they link all that professional knowledge in teams can they hope to effectively treat the whole person.

Quality is an attribute which Saskatchewan people have always sought and found in their health care providers. But that quality could be strengthened into true comprehensiveness if those providers worked in a partnership. Then the physician who is treating a patient for high blood pressure would be able to send that patient down the hall to a dietitian/nutritionist to get the best possible diet. Of particular importance is a new role and new responsibilities and new equality for nurses, who make up the single largest health care profession.

Of course, for this Commission and the health care system it envisions, it will not be good enough for people only in cities to have the kind of comprehensive treatment and services created by new partnerships in health care delivery. They must also be accessible in the rest of the province, especially for people who do not find it so easy to travel to cities for health care. The many older people in rural Saskatchewan could find that such health care teamwork could literally give them a new lease on life.

The team approach makes the focus on health, which the Commission has stressed, so much easier to achieve and likely to succeed. The partnerships it envisions include people who will focus on prevention and health promotion and protection against environmental problems that bring illness in their wake. Prevention and provision of care will intertwine in new and effective ways.

Many changes will be required in the delivery of professional health care services and in the education of professionals to accommodate these changes. In some fields, speaking of teams of professionals would be pointless unless plans and proposals were drawn up to train and recruit and retain such people, for they are in demand across the country.

This section of the report spells out the Commission's proposals for the health care professions on which we all depend, and makes clear how crucial they are to the new system recommended for Saskatchewan.

Physician Services and Practices

Throughout the Commission's hearings, presentations were made about the practice of medicine and the delivery of medical services in Saskatchewan. It became clear that there is a deep appreciation for the dedication of physicians in providing medical services throughout the province during its formative years. This history of dedication has contributed to a high dependence on sound judgments by physicians.

However, with the passage of time and changing circumstances, situations have developed which give rise to concern about how medicine is practised today. Several briefs, including some from physicians, referred to over-medication, excessive recall of patients, inadequate communication and consultation, and lack of sensitivity and compassion.

Questions were raised particularly about the factors motivating physicians to practise medicine "differently than they used to". Some physicians even suggested that today's system seems to have resulted in an "assembly line approach" to the delivery of medical services, with the "profit motive" becoming dominant.

Some presentations blamed the existing fee schedule for encouraging this kind of practice. It was suggested, for example, that payment for a quick checkup and a prescription does not truly reflect professionalism in the practice of medicine.

A physician, in his comments to the Commission, suggested that physicians should be practising in group practices. He said, *"The advances in medical knowledge, in diagnosis and treatment, as well as in related technology, have made it impossible for any one physician to be competent in all branches of medical practice."*

Some initiatives of the medical profession suggest that some "soul searching" is going on about how physicians can provide their services in a more extensive way. There appears to be a desire on the part of groups and individuals within the profession to find ways to respond to the new expectations and demands of the consumer which might also result in more professionally-satisfying circumstances for the delivery of medical services.

Some briefs discussed the possibility of involving other health care professionals in group medical practices, providing complementary services such as nutrition and therapy.

The Commission recognized that new approaches and systems should be proposed to provide new options and directions for the future.

RECOMMENDATIONS

4.1 The Government of Saskatchewan must establish a PHYSICIAN SERVICES REVIEW PANEL with representatives from the Department of Health, the College of Physicians and Surgeons, the Saskatchewan Medical Association and the Division Council Co-ordinating Board to conduct an in-depth analysis of existing legislation, regulations and payment systems, with a view to permitting the development and introduction of more options for the practice of medicine.

(a) The panel should have two representatives from each of the member organizations with an independent chairperson appointed by the Minister of Health.

(b) The panel must give priority to considering elements which would contribute to:

(i) the establishment of a system which would link three or more physicians in a complementary group practice.
(ii) the establishment of medical services centres (Refer to Recommendation 4.3) headed by physicians but involving other

health professionals in the delivery of service as a team.

(iii) the clarification and affirmation of the legal and funding status of the four existing community clinics.

4.2 **The model for delivery of medical services in rural communities should be based on a group practice consisting of a minimum of three physicians, and providing for a "one practice in two or three locations" concept where this is the most feasible arrangement.**

(a) Division councils must group acute care and long-term care facilities into geographic units which encourage inter-relationship and integration of medical and related services.

4.3 **Legislation must be enacted to provide for the establishment of MEDICAL SERVICES CENTRES which would allow and encourage medical practices to adopt an interdisciplinary professional health team approach to providing primary care.**

(a) The entry point to such centres would be through the physician but could result in the prescription of other services, including psychology, nutrition, nursing and family counselling.

(b) Funding policies must be modified to ensure compensation for the professionals working as a team with the physicians.

(c) Medical services centres could be established by a division council to serve a particular community or geographic area, or by a group of family physicians who wish to provide broader services.

(d) Medical services centres must be established with the concurrence of the division council which would be responsible for approving and providing funding through annual grants.

4.4 **The Department of Health must develop regulations for the establishment and operation of "minor emergency" or "walk-in" clinics to ensure that specific criteria about the clearly identified need for such a service, the quality of patient care, and the avoidance of unnecessary "add-on" costs to the medical care system are taken into consideration.**

(a) No physician should be permitted to own, operate, or invest in an emergency clinic unless this is his or her full-time practice setting.

(b) Emergency or walk-in clinics must not be permitted to be established as a business operation by individuals outside the medical profession.

(c) "Moonlighting" by residents and interns in minor emergency clinics should not be permitted.

(d) A transition strategy must be developed to permit the phasing out of established clinics which do not meet the new criteria.

4.5 The Department of Health must develop regulations which control radiology and other diagnostic services provided in minor emergency clinics and general practice offices, to ensure that such services are clinically justified, conducted by appropriately qualified professionals, and not needlessly duplicated in hospitals or radiologists' offices.

(a) The College of Physicians and Surgeons must develop medical guidelines and standards for the use of radiology and other diagnostic services in settings other than hospitals and radiologists' offices.

4.6 To ensure professional impartiality and independence in the referral of patients between general practitioners and specialist physicians, specialists must practise in settings distinct and apart from those of general practitioners.

(a) Specialists who practise in association with general practitioners should receive the general practitioner fee rates for patients referred to them.

Physician Supply and Distribution

Concerns expressed by various presenters during the Commission hearings made it evident the most serious problems of availability of medical services in Saskatchewan include:

- stability and continuity in general practitioner services in centres with less than 3,000 people.
- the availability of Saskatchewan graduates to serve in smaller centres.
- the availability of specialists in regional and large community hospitals and the division hospitals of the future.
- the availability of the more sophisticated specialties, such as organ transplants, for base hospitals.

The major problems identified with the location of doctors in smaller communities included the following:

- the practice of medicine on a solo basis which is considered by an increasing number of physicians as being inadequate for the delivery of a high quality of service.
- the lack of opportunity to use the skill and knowledge acquired during training.

- the situation of the two-career family in which frequently both partners are professionals who desire to practise their professions.
- the decreasing opportunity to socialize with people of one's age and interests.

The Commission carefully examined the numbers of rural physicians. It found there are far fewer physicians working in rural Saskatchewan today than there were 25 years ago. Many communities which had one physician in a solo practice in 1966 have none today. Other communities which once had two or even three physicians now have only one, and worry about keeping that one or finding a replacement if he or she should leave.

Almost without exception, these physicians are graduates of universities outside of Canada. In fact, Saskatchewan has an unusually high dependence on physicians trained in other provinces or beyond Canadian boundaries. Approximately 29% of specialists and 35% of general practitioners now working in the province are graduates of the University of Saskatchewan.

Over-supply does not seem to be a serious problem with the possible exception of general practitioners in Saskatoon and Regina. When population shifts and consumer preferences are taken into account, however, the current levels in the two cities, if maintained, cannot be considered a serious over-supply.

The Commission became much more concerned about some possible specialty shortages. The Saskatchewan Medical Association said in its brief: *"The waiting time for referral of patients to certain specialists has reached the point where the quality of care can be said to be declining. We speak of specialties such as cardiology, dermatology, psychiatry, rehabilitation medicine, nuclear medicine, general surgery, otolaryngology and ophthalmology."* It became evident the shortage of certain specialties was most acute in the present regional hospitals.

From the presentations made and from its own studies, the Commission concluded that clear directions for the future must be identified in order to ensure that:

- ongoing general practitioner services are available in designated settings within each health services division.
- Saskatchewan graduates are attracted to practise in communities other than the cities of this province.
- core specialties are available to provide the mandated services in the proposed division hospitals.
- there is a stable supply of the more sophisticated specialties for the base hospitals.

The Commission examined initiatives tried in other provinces for the redistribution of medical manpower from the largest residential centres to more remote communities and found that none of these have contributed to any effective or long-term or even acceptable solutions. It could not help but conclude that any approach which is restrictive or directive in nature is not going to work effectively.

It concluded that success in attracting physicians to practise in settings that are not frequently or readily chosen can only occur through positive incentives, imaginative recruitment and the creation of successful practice models.

RECOMMENDATIONS

4.7 **Each division council must develop a division-wide recruitment strategy which takes into account social, professional and economic factors, with a view to attracting physicians to its area and ensuring a high degree of stability and continuity of specialist and general practice medical services for division and community hospitals.**

(a) Recruitment incentives, which could include start-up grants, income support and payment of insurance premiums, should be developed by division councils.

(b) The mandate of each institution designated as a hospital must be clearly identified to indicate the scope of medical services required.

4.8 **Each division council must define the core of services to be offered at each division hospital and develop a manpower plan to ensure that an appropriate complement of specialists and general practitioners is available to provide the mandated services in a continuous and ongoing way.**

(a) The core specialist team identified with the designated division hospital should include Canadian-certified specialists in such areas as radiology, pathology and anaesthesiology, general internal medicine, general surgery and obstetrics and gynaecology.

4.9 **In areas outside the major division centres, each division council must group hospitals within designated geographic areas into a single co-ordinated hospital services unit for purposes of ensuring partnerships for medical practice.**

(a) This grouping should foster the concept of 'one hospital on three or four sites.'

4.10 **Provincial legislation must be modified to permit certain specialties which will be located only in base hospital centres to have "associate status" with division hospitals through formal agreements between division councils.**

(a) The "associate status" specialists would visit division hospitals regularly for day surgery, less complex procedures and consultations.

(b) The "associate status" specialties could include ophthalmology, otolaryngology and orthopaedics, among others.

4.11 The proposed Health Manpower Branch (Refer to Recommendation 5.24) of the Department of Health, in partnership with the Division Council Co-ordinating Board, the College of Physicians and Surgeons and the College of Medicine, must identify provincial manpower requirements - particularly in specialty areas - for the immediate and more distant futures and develop plans and policies for training and recruiting the required personnel so mandated acute care services can be provided without interruption.

(a) The plan must propose a system for the allocation of residency positions which reflects specialty requirements in the Saskatchewan setting and which minimizes the possibility of maldistribution.

(b) The plan for Saskatchewan must take into account levels of compensation, methods of compensation, opportunities to practise a specialty to the fullest degree, availability of technology and opportunities to break new ground.

4.12 For access to diagnostic and consultative capacities in larger health care institutions, rural division councils must establish sophisticated communication links between rural facilities and division hospitals, and arrange with the Regina and Saskatoon councils for such links between base hospitals and division hospitals.

(a) The Department of Health, in partnership with SaskTel, must develop a plan to link community hospitals with division hospitals, and division hospitals with base hospitals, and submit that plan to the division councils for their consideration and implementation.

Physician Reimbursement Systems

The great majority of physicians in Saskatchewan are paid on a fee-for-service basis through the Medical Care Insurance Branch of the Department of Health. This fee-for-service system was developed in the early 1960s and has remained relatively unchanged.

The Commission became abundantly aware that many circumstances and influences have profoundly affected the way medicine is practised and medical services delivered. It became aware of the introduction of many sophisticated technologies and of new, more highly trained specialists and sub-specialists. It also learned that consumer expectations have changed greatly with the passage of time.

Other factors identified as having an effect on the payments made for physician services include the significant change in the age distribution of the population, the shift from a rural population to an urban one, the changing mandates of hospitals and the changing attitudes and expectations of the medical profession itself.

The only changes there have been to the fee-for-service plan were in the fee schedule, after discussions and negotiations between representatives of the government and the medical profession. There has never been a major review which addressed certain needs and concerns and provided an orientation that reflects today's skills, knowledge, advances and expectations. Unquestionably, the original plan was tailor-made for Saskatchewan and for the province's circumstances at the time. The suit no longer fits; it needs major re-tailoring.

Several presentations expressed some dissatisfaction with the way the current system influences the practice of medicine. These, plus the Commission's analysis, suggest the system encourages the throughput of patients and does not necessarily mean services are offered on the basis of real need. It is very open-ended with no kinds of limits on the number of visits - illustrated by the very dramatic increase in the number of repeat visits to doctors' offices. The percentage of the population that sees a doctor in a year has not dramatically increased, but the number of medical services used has doubled in 20 years. This applies to all ages within the population.

The original system could not anticipate the style of practice that would develop. It does not encourage health promotion or quality of life through services by associated health professionals. Rather, it may have turned unnecessarily to technical procedures and prescription of medications. Representatives of the Joint Medical Professional Review Committee confirmed the system contributes at times to undesirable practices.

It has become evident that the payment system which has existed in this province for three decades has frequently contributed to care which is either inappropriate or ineffective. The Commission concluded that a major restructuring of the payment system is needed and that options to the fee-for-service model should be developed.

RECOMMENDATIONS

4.13 Under the auspices of the Medical Care Insurance Branch, the physician services review panel must undertake a thorough analysis of the existing payment system and prepare revisions which encourage more professional practice of medicine and prompt consideration of different organizational structures for the delivery of medical services.

(a) The existing fee schedule should be revised in a major way to reflect the variations in a physician's time required for a particular service and the contribution of various types of medical experts relative to essential knowledge and skills.

(b) A capitation system should be developed to permit an annual payment rate to a group practice for a comprehensive set of services delivered to a complete cross-section of the population, based on the number of patients, their age-sex distribution, and the roles of associated professionals in that practice.

(c) Policies must be developed that would permit division councils to enter into contracts with physician groups which would provide a defined range of services for a stipulated sum of money.

(d) Exclusive of any incentives designed to attract physicians into particular settings, a salary plan must be developed which would permit division councils to employ physicians, on a basis that would be uniform across the province, for a defined range of medical services.

4.14 Regardless of the form of their compensation, physicians must continue to submit itemized reports of all activities to the Medical Care Insurance Branch of the Department of Health so medical activities can be measured and monitored on a province-wide basis.

(a) On the basis of its analysis, the Joint Medical Professional Review Committee should recommend to the Medical Care Insurance Branch the recovering of funds where inappropriate practices or services have been discovered.

4.15 The Medical Care Insurance Branch must develop processes to provide each division council with a complete report and analysis of volume, type and source of medical services delivered to the population of the division, including inter-divisional comparisons and provincial averages.

(a) Division councils should use this information to analyse the adequacy of division-based medical services and should develop plans to improve those services and educate the public in their use.

4.16 The mandate of the Joint Medical Professional Review Committee must be expanded to include the ability to develop and enforce payment regulations related to patterns of medical practice, which would include monitoring the number of procedures performed and the need for certain procedures.

(a) The medical practice protocol developed by the College of Physicians and Surgeons for the management of hospital utilization should be one of the bases for the analysis undertaken by the Joint Medical Professional Review Committee.

(b) Membership of the Joint Medical Professional Review Committee should be expanded to include two additional members appointed by the Division Council Co-ordinating Board.

4.17 The Government of Saskatchewan should enact legislation which would provide the College of Physicians and Surgeons with access to information systems in a physician's office for the purpose of an audit designed to ensure the highest quality of service is provided.

(a) The audits should be undertaken as part of a random sampling plan which is not motivated by punitive considerations.

4.18 Division councils should enter into contracts with a physician or physicians to provide general medical services for the residents of each supportive care centre operating under its jurisdiction.

(a) The contract could employ the capitation approach which identifies the range of services provided on behalf of a specified number of residents.

Physician Education Programs

In listening to presentations and analysing some recent studies, the Commission became aware of the fact that medical education programs and services have to change in a number of ways to keep pace with changing circumstances, developments and needs. When the College of Medicine was first established at the University of Saskatchewan, it was impossible to anticipate the rapid scientific development, technological advances and demographic modifications which have occurred in the past decades. The Commission observes that medical knowledge and technology will continue to expand in the future, Saskatchewan society will continue to change, and the Saskatchewan public will continue to expect the medical college to provide leadership.

All these factors will affect the educational programs which prepare young men and women to qualify as physicians, and the in-service education needed to maintain a high level of skills.

The Commission became particularly aware of certain pressing problems which exist in the province at the moment. These include:

- a lack of success in getting Saskatchewan graduates to locate in adequate numbers outside of Saskatoon and Regina.
- increasing difficulty in retaining in Saskatchewan the services of Saskatchewan-

trained specialists, a problem that will be exacerbated by the many retirements expected in the near future.

- the lack of an overall plan to focus on areas such as geriatric and rehabilitative medicine in the Saskatchewan setting.
- the lack of a forward-looking plan which utilizes highly-sophisticated communications technology, continuing medical education and clinical support systems.
- the lack of any special strategy to bring candidates of native ancestry into the medical training program.
- the lack of appropriate levels of funding for the College to carry out and develop new initiatives with respect to its academic mandate.

The Commission concludes that a special determination is needed on the part of the Government, the University and the College of Medicine to overcome some of the obstacles which are apparent, including funding shortfalls, an attitude of resistance to change, and existing structures and policies.

Despite its relatively small size, the Saskatchewan College of Medicine has led in a number of new developments since its inception. Factors are in place today which are contributing to a waning of that vitality. However, new directions can result in renewed prominence on the medical education scene.

The Commission has studied the report, *Towards a New Beginning*, produced by Dr. Kerr White after his review of the College of Medicine at the University of Saskatchewan. It was impressed with the depth of the review and is convinced the report's recommendations must receive serious consideration if the College is to fulfil its mandate in the Saskatchewan setting in the most effective manner for this decade and the 2000s.

RECOMMENDATIONS

4.19 The College of Medicine, in partnership with the Departments of Education and Health and the University of Saskatchewan, must develop a "mandate of the future" which clearly reflects its Saskatchewan setting, anticipated advances in technological and specialty services, and the interdependence and complementarity of roles among the five Colleges of Medicine in Saskatchewan, Alberta, British Columbia and Manitoba.

(a) This "mandate of the future" should be developed by a five-member task force consisting of the Associate Deputy Minister of Education responsible for advanced education, the Associate Deputy Minister of Health responsible for professional services, the Vice-President of the University of Saskatchewan responsible for the health sciences, the Dean of Medicine and the Chairperson of the Division Council Co-ordinating Board.

(b) To provide a more adequate financial base which ensures that the College of Medicine can develop this mandate, its funding levels must be significantly upgraded.

(c) The new mandate should be developed in consultation with the deans of medicine in Alberta, Manitoba, and British Columbia.

(d) The "mandate of the future" should reflect the analysis, directions and recommendations in the report, *Towards a New Beginning*, by Dr. Kerr White.

4.20 The College of Medicine should group the educational programs that make up its "mandate of the future" into four major categories - a basic undergraduate program, a core postgraduate training program, a priority one category and a priority two category - to reflect the most appropriate mandate of a medical training program in a Saskatchewan setting.

(a) The core postgraduate program should consist of those specialty areas which set a high standard for achieving accreditation by the College of Medicine.

(b) The "priority one" category should consist of those specialty programs which reflect initiatives and developments founded on the historical contribution which the College of Medicine has made in the Saskatchewan and Canadian settings, as well as addressing the particular specialty requirements in this province.

(c) The "priority two" category should consist of those other highly specialized programs which personnel and financial resources permit to be undertaken and continued over a period of years.

4.21 The University of Saskatchewan and the College of Medicine must ensure that, as a foundation for the medical training program, a strong basic sciences program exists which attracts a staff with a strong academic teaching and research orientation and which provides the base for the medical expertise required by today's graduates.

(a) The University of Saskatchewan and the Government of Saskatchewan must give immediate consideration to developing a funding plan which would ensure that the appropriate and unencumbered infrastructure exists to facilitate research.

(b) To provide the basis for research activity to compare with other provinces and to utilize the extensive data which is available to assist in capturing matching grants from outside sources, the Department of Health must set a target of 1% of its total budget for health research activities.

(c) The College of Medicine must develop a strategy, in partnership with the Saskatchewan Health Research Board, for encouraging epidemiological research which would provide the basis for determining future health directions and initiatives.

4.22 **The College of Medicine must develop new future-oriented strategies for recruiting highly-qualified and respected candidates for the faculty of medicine at a time when those candidates can choose among many opportunities to apply their knowledge and the competition for their services has increased.**

(a) The funding formulas and policies must be reviewed and modified to ensure they provide incomes in keeping with those available in other medical colleges in Canada and take into account the income potential in private practice.

(b) The funding formula and the actual income earned by a full-time faculty member must recognize and emphasize the teaching and research roles and the clinical services that member provides.

(c) In accordance with the recommendations in the report, *Towards a New Beginning* by Dr. Kerr White, the University of Saskatchewan Board of Governors should create a **College of Medicine Board** and assign to it responsibilities necessary to achieve the purposes of the clinical services fund.

4.23 **In addition to the internship and residency opportunities provided at the base hospitals in Saskatoon and Regina, the councils of the other health services divisions must develop, with the College of Medicine, clearly defined training opportunities for graduates to gain medical practice experience in "model" rural settings.**

(a) The "training units" should be designated on the basis of the teaching capabilities and interests of the medical practitioners involved, the role models they can provide for graduates preparing to enter the practice of medicine, the breadth of experience interns and residents can gain in the particular setting, and the availability of resources from the College of Medicine.

(b) The division councils should enter into formal agreements with the College of Medicine to ensure that a number of interns and residents are referred for their practical experience to these division training units.

4.24 The College of Medicine must develop a pro-active program designed to attract students of native ancestry to enrol in the college each year.

(a) The native/Indian institutes and colleges must co-operatively develop, in consultation with the College of Medicine, a special program for students of native ancestry who need to upgrade their academic standards to gain admission to the college each year.

(b) In partnership with the colleges, the Department of Education must develop incentives to encourage students to undertake the upgrading programs to enrol in the College of Medicine.

Nursing Roles in the Future

The Commission received briefs from the Saskatchewan Registered Nurses' Association and the Saskatchewan Union of Nurses, and local chapters of these organizations, in which concerns and expectations were expressed about the new demands made of nurses, the new knowledge which is required, the different responsibilities which have developed and their expanded roles in different settings. It became evident the nursing profession is in transition from a largely supportive role to a partnership in the delivery of health care services.

At the same time, the Commission became aware that nurses have some real difficulty trying to break with tradition. There appeared on occasion to be an unwillingness to assign some of the less professional tasks to support staff at the same time as new and more challenging responsibilities were being assumed. There appeared to be an unwillingness to accept that medication counselling is a more appropriate bedside nursing function for a highly-trained professional person than hair-washing. Indeed, it appeared to the Commission that tasks and responsibilities must be reassigned if the professional role is going to be enhanced and expanded training programs justified.

It is also true that other health care professionals, and hospitals, have a tendency to hold on to the traditional notions of nursing. The manner in which medical and hospital services are delivered today suggest different relationships and expectations for nurses. It was interesting for the Commission to learn from the Saskatchewan Registered Nurses' Association that half of all nurses employed in Saskatchewan in 1989 were working part-time.

Commissioners observed that the general public holds the nursing profession in high regard, but the knowledge and skills possessed by members of the profession are not being used in the most professional manner. There are many instances where the nurse should become "gatekeeper" to the health care system and more of a partner whose opinions about treatment protocols are sought.

It became very evident that redirection, redefinition and re-orientation of the nursing profession are needed to reflect very different circumstances in the delivery of health services.

RECOMMENDATIONS

4.25 The nursing profession of Saskatchewan, through its existing organizations and institutions, must immediately redefine its mandate to reflect the increased professional responsibility, knowledge and expertise associated with the practice of nursing in a setting characterized by sophisticated advances in the delivery of health care.

(a) The nursing profession must commit itself to the newly-stated professional mandate and must strive to have it reflected in educational programs, employment practices, payment systems and in-service education.

(b) The mandate must define, in specific terms, what constitutes professional nursing practice compared to activities that might be performed by supportive staff under the direction of a nurse.

4.26 Each division council, through a consultation process with the medical profession and other appropriate health care professional representatives, must develop a plan to ensure institutional and community-based services and practices provide nurses with the opportunities to fulfil an expanded professional role.

(a) In a number of settings, especially in rural Saskatchewan, arrangements and opportunities must be provided for a registered nurse to become the primary care health professional.

(b) In examining the role of the nurse to make it more professional, opportunities should be provided for consultation with the ancillary professions.

Nurses' Expanded Responsibilities

The Commission received a number of briefs from representatives of the nursing profession which indicated a willingness to assume new responsibilities and pursue new approaches to the delivery of nursing services in institutional, clinical and community settings. When these proposals are analysed, it becomes evident the profession recognizes significant changes have occurred in terms of where people want their health care services and how they want them delivered.

It was particularly significant that the Commission received a number of suggestions that nurses become the first contact for people seeking health care. The possibility was raised that some people who appear at medical or emergency clinics could very well be handled by a specially-qualified nurse, and it was suggested that often such contact might serve patients' interests more effectively.

Thus it was proposed primary care could become the responsibility of the nursing profession to a far greater degree than it is now.

The Commission also became aware of an increasing degree of territorialism creeping into the delivery of community-based services. The need to differentiate to the degree that occurs at present among the roles of public health nurses and home care nurses was questioned. The Commission was challenged to consider the possibility of far more co-ordination of community-based services.

With respect to institutional nursing, serious concerns were expressed about existing policies and arrangements for the delivery of services. These include:

- the increasing demand for specialized services without the opportunity to receive the necessary training.
- the lack of pay differential between more basic positions and those requiring additional training and expertise.
- the lack of opportunity to be involved in planning and decision-making.
- work environments characterized by rotating shift work, multiple bosses and rigid work rules.

It became very apparent that new directions and approaches must be considered to adjust workplaces to reflect current needs and expectations.

RECOMMENDATIONS

4.27 The category of PRIMARY CARE NURSE, requiring specialized training, must be created to be the first-contact health care professional in specified settings and circumstances.

(a) The primary health care nurse designation should require the equivalent of one full academic term of post-BSN training, including general, medical and pharmaceutical aspects.

(b) Primary health care nurses should be designated as the professionals in charge of family health care centres wherever these are established, but most particularly in those institutions whose mandates have been redefined from acute care to family care.

(c) Primary care nurses should have a special responsibility for services in designated communities in Northern Saskatchewan and should require in their post-basic training a program component focusing on the special needs of northern communities.

4.28 **The community nurse designation must be expanded to include the broad scope of community-based services and amalgamate traditional public health nursing and home care nursing services.**

(a) Community nurses should be responsible for a range of programs which would include adult counselling clinics, home visits and assessments, school and pre-school services, immunization and screening, adult blood pressure testing and pre-natal and post-natal education.

4.29 **Division councils, in consultation with the Saskatchewan Registered Nurses' Association and the Department of Health, must require the health care institutions within their jurisdictions to develop policies which ensure nurses have more opportunity than exists today to use their professional skills and knowledge to care for patients, and which minimize their non-nursing tasks.**

(a) To ensure that nurses are provided with the opportunity to carry out their nursing responsibilities to the greatest degree possible, ward teams of people responsible for support services, including record-keeping, portering and housekeeping, must be in place, around-the-clock as necessary in the larger institutions.

(b) Division councils should develop policies which require hospitals and supportive care centres to ensure the appropriate ratios of certified nursing assistants to professional nurses.

(c) The Department of Health must alter the funding formula to reflect division councils' need for enough flexibility to require the institutions within their jurisdiction to develop appropriate mixes of professional and support staff that reflect the varying mandates and sizes of the institutions .

4.30 **Carrying out the treatment regimen prescribed by physicians for each patient must become the primary responsibility of the nurses who are in charge of a ward in a larger hospital or who are responsible for a combination of wards in a smaller hospital.**

(a) The nurse in charge must provide for the co-ordination of such care services as physical therapy, occupational therapy, diagnostic tests and pharmacy on a 24-hour basis, as required by each patient.

4.31 Provincially-negotiated contracts and division councils' policies must ensure institutions provide working conditions for nurses which reflect their professional role, with particular attention to innovative staffing approaches, hours of work, pay differentials for shifts, and proper orientation.

(a) Institutions should have the flexibility to develop staffing policies which permit flexibility in hours of work, to ensure shifts are the most effective length for the wards involved, and allow the use of primary care teams, job sharing, and improved rotation schedules drawn up wherever possible with input from the staff involved.

(b) Institutions should have the flexibility to increase the differentials paid to nurses who work shifts on evenings, nights, weekends and holidays to ensure they are reasonable and realistic.

(c) Staffing plans must ensure a proper orientation period for nurses new to a ward, varying in length according to the demands of the ward.

(d) Staff development and training opportunities should be made available to nurses on an ongoing basis.

(e) To facilitate proper staffing throughout a 24-hour period, division councils should develop plans for child-care centres which are located in particular institutions, or shared among them.

4.32 Division councils must require base and division hospitals within their jurisdictions to redraft their bylaws to provide for a new internal body to be known as the HOSPITAL PROFESSIONAL ADVISORY COMMITTEE, to advise on such key topics as standards of practice, resource requirements of new program proposals, and quality of care.

(a) Members of the hospital professional advisory committee should include senior clinical nursing representatives from all areas of the facility plus representatives of related non-medical, clinically-oriented professions such as pharmacy, physical therapy, occupational therapy and dietetics.

(b) The hospital professional advisory committee should be analogous to the medical advisory committee and report to the hospital management at the same level, and provision must be made for liaison between the two committees, which could include the exchange of minutes and reports.

Nursing Education

Nurses are trained in Saskatchewan in three different ways. The College of Nursing at the University of Saskatchewan offers a four-year program leading to a Bachelor of Science in Nursing degree, and enrols 60 students a year. The Saskatchewan Institute of Applied Science and Technology offers two-year programs leading to a diploma in nursing at both its Wascana campus in Regina and its Kelsey campus in Saskatoon, with about 300 students enrolled each year. A two-year diploma program offered through the Saskatchewan Indian Institute of Technologies at North Battleford, in co-operation with Kelsey, enrols about 20 people each year.

The Commission believes the new role it envisions for the nurse - with expanded professional responsibilities as partner in the health care team and leader of the family health care centre - will in the longer term require more training than is currently provided in the non-degree program.

It also believes the advances being made in specialization of care and the development of technology demand increased opportunities for nurses to specialize more, in both training and practice, than they can at present. The knowledge and skill required of a neonatal intensive care nurse are quite different from the knowledge and skill required of a psychogeriatric nurse working with cognitively impaired seniors.

It envisages nurses increasingly becoming more equal partners in the delivery of medical and hospital services, especially in the area of treatment. This reinforces its belief that expanded opportunities for training are necessary.

However, there are certain realities of nursing in Saskatchewan which make the Commission aware that quantum leaps toward a target of better-trained nurses could make achieving that goal more difficult. Saskatchewan needs about 9,000 nurses working in its many health care settings every year, and must maintain that level while it moves in a careful, well-planned way towards the goal of eventually ensuring that every nurse has a Bachelor of Science in Nursing.

The provincial government, which provides the funding for the province's nursing programs, and the educational institutions that offer the programs leading to this degree, must make collaboration to reach this goal, without disrupting the supply of nurses, a crucial part of their health care policies and priorities.

RECOMMENDATIONS

4.33 A NURSING EDUCATION COUNCIL must be established by the provincial government to develop and oversee the application of a co-ordinated and integrated approach to nursing education which will result in an ongoing articulation of the programs offered by the University of Saskatchewan and the Saskatchewan Institute of Applied Science and Technology.

(a) Membership of the Nursing Education Council should include representatives of the Saskatchewan Registered Nurses' Association, the Saskatchewan Institute of Applied Science and Technology, the University of Saskatchewan, the University of Regina, and the Departments of Health and Education.

(b) The goal of the articulation of the nursing programs must be to permit nursing students to progress smoothly from the Saskatchewan Institute of Applied Science and Technology to the University of Saskatchewan without any kind of obstacles or loss of credits or time.

(c) The Nursing Education Council must develop a strategy to ensure a more comprehensive and extensive program of practicums for nursing students to ensure first-hand experience in institutional and community settings, with a special emphasis on providing opportunities in rural and Northern Saskatchewan.

4.34 The Nursing Education Council, in partnership with the Departments of Health and Education, must establish as a long-term target a steady increase in the percentage of Saskatchewan nurses who acquire a Bachelor of Science in Nursing degree as the basic requirement for the practice of nursing, and develop a strategy to achieve it.

(a) The plan should identify the financial and personnel resources required to achieve this goal, and establish the appropriate incentives to ensure that 20% of Saskatchewan Institute of Applied Science and Technology graduates will continue their training at the College of Nursing by 1992, rising to 40% over a period of 10 years.

4.35 To address the nursing shortage which is anticipated for Saskatchewan and to ensure the province's need for nurses is met, the Department of Education must immediately increase by 50 the number of training places in the diploma nursing program at the Saskatchewan Institute of Applied Science and Technology, and provide the funding for such an increase.

(a) The Nursing Education Council should examine the possible need for a further increase in enrolment in the program.

4.36 The Nursing Education Council must develop a comprehensive program to increase the opportunities for nurses to specialize in their chosen fields, once they have achieved the bachelor's degree, to meet the growing demands of health care specialization and technological development.

(a) Opportunities should be available at three levels of training and specialization:

(i) One academic term of post-BSN training or an approved internship program leading to an advanced nursing certificate, for those areas in which the focus is on only one specialty and some additional knowledge is required beyond the basic program, such as psychogeriatrics, orthopaedics or long-term care.

(ii) A full university year of post-BSN training leading to a specialist certificate, for more complex areas such as psychiatry or critical care, and to train primary care nurses.

(iii) A full program leading to a masters of science in nursing, which permits more complex specialization.

(b) The global funding provided to the University of Saskatchewan by the Department of Education must recognize the extra demand on the College of Nursing to increase the number of nurses graduating with a bachelor's degree.

4.37 In consultation with the Nursing Education Council, division councils must develop plans which will identify opportunities for and encourage students to do the practical periods of training that are part of the nursing program in community settings and hospitals throughout the province.

Psychiatric Nursing Services

The Commission received many briefs concerning the lack of adequate professional services for the mentally ill throughout the province. Concern was particularly expressed about the inadequacy of the psychiatric nursing services due to general staff shortages, and also to the maldistribution of resources. Frequently, these have resulted in an interruption of services for some of the mentally ill and a lack of professional contact to provide personal supports and to monitor treatment regimens.

Commissioners also became aware that some very special components in the psychiatric nursing service distinguish it from the nursing profession as a whole. As one person suggested to the Commission, psychiatric nurses enter their profession with a "different mindset", and they maintain that distinction throughout their years of service. There was an inclination for those choosing psychiatric nursing to focus to a greater degree on social and human relationship issues and problems. Thus the Commission concluded that the psychiatric nurse is "a different kind of nurse".

At the same time, a number of indicators suggest increased opportunities should be provided for psychiatric nurses to pursue a university training program leading to a bachelor's degree, as well as post-degree specialization. This is prompted by the facts that increased knowledge about the treatment of mental illness, increased specialization on the part of other mental health professionals, and increased expectations on the part of patients and their families require more basic and specialized training.

The Commission became aware the psychiatric nursing graduates in Saskatchewan are being actively recruited by other provinces. This is prompted by the existence of shortages throughout Canada and by the regard for the Saskatchewan program. As a matter of fact, provinces which have no psychiatric nursing training program are the ones which seem to be experiencing the more critical shortages.

RECOMMENDATIONS

4.38 A psychiatric nursing training program must continue to be offered under the auspices of the Saskatchewan Institute of Applied Science and Technology to ensure that an adequate number of graduates is available to serve the people with mental illnesses in Saskatchewan.

(a) The first year of the program must continue to be offered in common with those students registered in the RN and CNA programs.

(b) The number of training spaces for students entering the psychiatric program each year should be maintained at 110 to 120.

4.39 The Wascana and Kelsey campuses of the Saskatchewan Institute of Applied Science and Technology must have a uniform policy of providing the opportunity for graduates from the psychiatric nursing program to pursue studies for an RN qualification if they choose to do so.

(a) The requirements for entry to the RN qualification program from the Wascana and Kelsey programs should be identical, and should amount to one year of additional training.

4.40 Formal arrangements must be developed by the Departments of Education and Health with the University of Brandon in Manitoba and Douglas College in British Columbia to provide enhanced opportunities for registered psychiatric nurses to obtain bachelor's degrees with a specialization in psychiatric nursing.

(a) The formal arrangements with the two institutions must provide for both on-campus and long distance education components leading to graduation.

(b) The arrangements should result in 20% to 25% of all psychiatric nurses having a bachelor's degree in 10 years.

Independent Health Professionals

Independent health professionals such as optometrists, pharmacists, chiropractors and dentists provide health services to the people of Saskatchewan, in many cases without referrals from physicians. Optometrists and chiropractors in private practice are paid on a fee-for-service basis by the Department of Health, and also by patients, to a certain extent. Dentists are primarily paid directly by their patients, and independently operating pharmacists receive their income through a combination of consumer charges and funding by the Department of Health.

After hearing their briefs and after its own analysis, the Commission has concluded the existing framework for the services of these independent health practitioners has worked in a satisfactory way for both practitioners and the general public. In most instances, it received no briefs that revealed problems with the way in which such services are delivered, except for concerns about the Children's Dental Program.

However, from the briefs it received on behalf of these independent health professions and from its own information, the Commission has identified some concerns affecting each of these professions which require it to recommend some new directions.

In the last few years, disagreement has arisen between the Saskatchewan Association of Optometrists and the Saskatchewan Ophthalmic Dispensers Association over the question of eyewear prescriptions. The Commission believes this issue would be resolved by general acceptance of the concept that the prescription is the property of the patient, a position which the Saskatchewan Association of Optometrists has reaffirmed among its members.

Pharmacists are responding to changes in the practice of their profession brought on by the explosion of new drug products in the last 20 years and the use of computers to monitor and process drug information. They are putting new emphasis on pharmaco-epidemiology, patient education and counselling, and need more opportunities to be the professionals they are.

Chiropractors, in their brief, asked for access to hospital radiology and laboratory facilities and the Commission has concluded the granting of such privileges is justified, within certain well-defined parameters, to avoid duplication of X-rays. There are no user charges for chiropractic services, which are publicly insured. In the past decade, utilization of chiropractic services has tripled, the only area of health care where this kind of dramatic increase has occurred.

The dental health of the Saskatchewan population is improving and dental decay is on the decline. As a result, the practice of dentistry is changing from restorative work to preventive periodontic and orthodontic work. The Commission found, however, there is a shortage of dental services for the residents of long-term care centres.

Generally, the Commission has concluded this province compares favorably with the rest of Canada in the supply and distribution of these health professionals.

RECOMMENDATIONS

4.41 The Department of Health must ensure policies and procedures of Saskatchewan optometrists adhere to the principle that a prescription for eyewear is the property of the patient and must be given to the patient when an examination is completed.

(a) The Saskatchewan Association of Optometrists must continue its efforts to inform its members of their responsibility to adhere to this principle.

(b) The Optometry Act should be amended to include a provision which requires a practising optometrist to present a prescription to a patient without any conditions.

4.42 The Saskatchewan Pharmaceutical Association and the College of Pharmacy, University of Saskatchewan, must develop new strategies to enable pharmacists to use their professional knowledge and skills to determine medical protocols for individual patients and provide support and interpretive counselling to them.

(a) To ensure the professional role of pharmacists is enhanced, the College of Physicians and Surgeons and the Saskatchewan Pharmaceutical Association should undertake to review or determine how the roles of physicians and pharmacists could be more complementary.

4.43 The Department of Health should adopt a policy of insuring a specified number of chiropractic services for a person during a year, with the individual assuming responsibility for part of the cost of any additional services used during the same year.

(a) The first 12 chiropractic services each year should be completely paid for by the Department of Health, and 50% of the cost of any additional services should be paid for by the individual.

4.44 Chiropractors holding a valid membership in the Chiropractors Association of Saskatchewan should have the right to apply for courtesy privileges within a neighboring hospital which would enable them to order X-rays for skeletal examinations.

4.45 Since residents of supportive care centres may not have a dentist or be able to visit a dentist, each division council should contract with dentists working in communities which have supportive care centres for the provision of basic dental services in those centres.

Allied Health Professionals

During its examination and analysis of the Saskatchewan health care situation, the Commission developed an increasing appreciation for the contribution which an expanded team of health professionals can make to such care because of its varied expertise, knowledge and skills.

It received many briefs which made clear that increasing importance is being attached to rehabilitation services which help people return to normal life after an injury or illness, and consultative services which are intended to help the elderly and others to continue doing the things they have always done as normally as possible for as long as possible.

The Commission quickly realized, however, the trained professionals who provide these important services are in short supply, particularly in rural and Northern Saskatchewan. The province is understaffed in a number of areas, most particularly in the therapy and nutrition fields.

There is a particular need for physical therapists and occupational therapists; their workloads are increasing dramatically as the population ages and suffers more hip fractures, strokes and general debilitation.

At present, the School of Physical Therapy at the University of Saskatchewan is concerned there is no long-term provincial funding commitment to maintain enrolment at the current level of 30 students a year.

The province is suffering from a severe shortage of occupational therapists, the Commission was told, and the situation is steadily growing worse. The Saskatchewan Society of Occupational Therapists has only 96 active members registered and one-third of those work part-time.

For a variety of reasons including non-competitive benefit packages and general professional shortages, Saskatchewan experiences difficulty in recruiting and retaining speech and language pathologists, as well as audiologists. These professionals must receive their training outside of Saskatchewan, as a training program is not available in the province; in fact, many obtain their degrees outside Canada. The staffing situation is compounded by the lack of any legislation to license and regulate speech and language and audiology practice in this province.

The Commission was told that Saskatchewan also has a shortage of qualified dietitians/nutritionists, particularly in rural areas. Nutrition plays an important role in preventing illness and maintaining wellness for the elderly, and lifelong dietary habits can contribute to many of the diseases that commonly occur among seniors, such as heart disease. More emphasis on nutrition counselling for seniors is needed, but there are many other groups that would also benefit from such counselling.

The University of Saskatchewan graduates 25 students a year with a Bachelor of Science Nutrition degree, and it must be asked whether this will be enough to meet the growing need the Commission foresees. At present, only 12 intern positions are available in the province, even though an internship must be completed for a graduate to become a qualified dietitian.

Saskatchewan residents are eligible to receive professional services without charge at the 33 provincially-funded chiropody clinics. If special footwear or orthotics are required, the patient is charged the actual purchase price. Twelve chiropodists and 12 chiropody assistants are salaried employees of the Community Health Services Branch of the Department of Health; they believe services to the aging rural population should be improved.

Compounding the problem of obtaining allied health professionals is the fact that interprovincial competition for their services is exceedingly keen. It became clear that to attract and retain such professionals, a relatively small province like Saskatchewan must develop creative and aggressive strategies that will enable it to hold its own in the competition.

RECOMMENDATIONS

4.46 Therapy services throughout the province should be combined into therapy program units consisting of physical, occupational, and speech and language components, established by division councils and staffed by a team of professional and supportive staff employed by the councils.

(a) The therapy teams should be responsible for all therapy services wherever they have to be delivered; i.e. community settings, institutions, family health care centres, rehabilitation facilities and the homes of patients, and on a regular outreach basis to outlying facilities and family health care centres.

(b) In larger institutions such as base hospitals, therapy services should be provided by resident therapists.

(c) Independent of the division council teams, therapists may also be associated with physicians and other health care professionals in medical services centres.

(d) Appropriate targets for ratios of such therapists to the population served might be:

(i) one physical therapist per 4,000 population
(ii) one occupational therapist per 10,000 population
(iii) one speech and language pathologist per 20,000 population

4.47 The University of Saskatchewan should create a new School of Rehabilitation Sciences which includes the present School of Physical Therapy and a new program of occupational therapy.

(a) The two programs should share a common core of subjects before students specialize.

(b) Provincial funding should continue to provide adequate resources for the School of Rehabilitation Services to maintain the present intake of 30 students to the physical therapy program.

(c) The occupational therapy program should graduate 18 students a year.

4.48 The Government of Saskatchewan should enter into contracts with people who want to train as speech and language pathologists and audiologists at universities outside Saskatchewan, offering bursaries with a built-in commitment to return to the province to practise, plus other incentives.

(a) As an encouragement to graduates to return to practise in Saskatchewan, the contracts should provide guaranteed employment.

4.49 The Government of Saskatchewan should pass a special act of the legislature to give speech and language pathologists and audiologists professional status and regulate the professions.

4.50 Each division council must employ dietitians/nutritionists within its institutions and as part of its community-based health services team, to provide services such as educational programming for groups, individual counselling, advising institutions on their food services, and working with patients referred by physicians.

(a) The nutritionists/dietitians should provide outreach services to outlying facilities and locations.

(b) Dietitians/nutritionists should be employed by division councils in numbers that take into account the total population of the division, the percentage of seniors and the number of institutional beds, with a suggested ratio of one per 5,500 people.

(c) Division councils should work with the University of Saskatchewan to provide enough dietetic internship positions to handle the entire graduating class of the program.

4.51 Each division council must offer a chiropody service provided by a team of chiropodists and chiropody assistants in conveniently-located clinics throughout the division.

(a) The appropriate ratio of chiropodists might be one per 50,000 population.

Ancillary Health Professions

The Commission quickly became aware of the special importance of support personnel such as certified nursing assistants, emergency medical technicians, and registered respiratory therapists in the health care field. They all belong to groups with a focus on particular skills and capabilities which complement the services of the primary caregivers. They have a special responsibility through these skills to contribute to the highest quality of health care; without them, the primary caregivers cannot do the best possible job.

The Commission learned there is a serious shortage of emergency medical technicians (EMTs) and the ambulance industry is having major difficulties recruiting and retaining qualified people. *"High turnover rates, vacancy rates, and a great difficulty in recruiting EMTs create many unnecessary problems for ambulance operators,"* the Saskatchewan Ambulance Association said in its brief. In the last eight years, the Saskatchewan Institute of Applied Science and Technology has graduated 976 EMTs from its six-week training program, but there were only 560 working in Saskatchewan as of December 31, 1989. There were 43 people working in the province who have the advanced training that qualifies them to be an advanced emergency medical technician (EMT-A).

These problems become even more important when they are put into the context of this report's recommendations for medical transportation services within each health services division. The development of the sophisticated medical transportation program needed for Saskatchewan is dependent upon an adequate supply of qualified emergency services personnel.

Another difficulty the Commission has discovered is that Saskatchewan hospitals, like those in the rest of Canada, are having difficulty recruiting and retaining registered respiratory therapists despite highly competitive salaries. Such therapists assist physicians in the diagnosis and treatment of people with respiratory and associated disorders.

The Commission's recommendations for a new, more professional role for nurses leading teams of hospital ward staff will have an effect on the certified nursing assistants (CNAs). The team approach will need to make greater use of CNAs. Furthermore, the growing shortage of nursing personnel will necessitate a division of labor, and CNAs will undoubtedly be delivering more of the basic bedside care duties as the more highly trained and skilled nurses undertake the duties which require professional training and skill.

RECOMMENDATIONS

4.52 A central division ambulance services unit which can provide the most sophisticated lifesaving support systems must be staffed by personnel with various levels of training, including the basic emergency medical technicians (EMTs), advanced emergency medical technicians (EMT-As) and paramedics (EMT-Ps).

(a) The suggested complement of core staff for the division unit headquarters is eight EMTs, two EMT-As and one EMT-P per 50,000 population.

(b) In addition to the emergency services they provide, paramedics should perform supervisory, training and support functions for the division medical transportation system.

(c) The Department of Health and division councils must give special attention to the salaries and working conditions of emergency medical personnel to enable Saskatchewan to successfully compete with other provinces in their recruitment and retention.

4.53 **Long-term agreements for the training of respiratory therapists must be formalized between the Saskatchewan Department of Education and the Southern Alberta Institute of Technology in Calgary and the Northern Alberta Institute of Technology in Edmonton for the training of five students a year in each institute.**

(a) The agreement negotiated should call for the first year of training to be at the institutes, and the practical component of the second year at an appropriate Saskatchewan hospital selected by the student before enrolling, and arranged with the hospital.

4.54 **Division councils must provide the basis for health care institutions to establish policies, in accordance with provincially-defined standards, which determine the nursing services staff mix on each ward and which suggest particularly the ratio of certified nursing assistants to professional nurses.**

(a) Policies of hospitals and supportive care centres should clearly define the scope of responsibility of certified nursing assistants in relation to registered nurses.

4.55 **The Department of Health, in co-operation with the Department of Education, must establish a one-year rehabilitation therapy program to train CERTIFIED THERAPY ASSISTANTS who would work as members of the division therapy team under the direction of physical and occupational therapists.**

(a) Government regulations should be developed to provide for certification of therapy assistants.

(b) The certified therapy assistants would deliver the 'outreach' services in homes, family health care centres and supportive care centres in communities throughout the province.

Continuing Education for Health Professionals

The Commission was impressed with the importance attached to the need for continuing education in the case of all health professionals, whether physicians, nurses, therapists, dentists or chiropractors. The stress on expanded opportunities was in large part prompted by the fact that new developments are constantly occurring which affect the practice of the various professions. There is an evident desire on the part of these professionals to keep pace with the ever-expanding scope of knowledge and understanding of maintaining health and treating illness.

The Saskatchewan setting makes it particularly important that a co-ordinated system for continuing education use communications technology which takes the message to where the health professional is located. A need was expressed for increasing the sense of support for practitioners in the rural settings.

Despite the commitment to the notion of distance education for the purposes of in-service and the acquisition of additional training which might lead to increased specialization, there has been very little co-ordinated effort among the various disciplines. It becomes quite obvious that Saskatchewan, by comparison with some other locations, has not developed a plan which recognizes the need for some interdisciplinary education approaches, and the means available today for involving people who live long distances from larger centres.

RECOMMENDATIONS

4.56 A HEALTH SCIENCES SCHOOL FOR CONTINUING EDUCATION must be established which would actively involve each of the health science faculties at the University of Saskatchewan and the Saskatchewan Institute of Applied Science and Technology in developing a sophisticated, comprehensive and co-ordinated distance education program focusing on in-service training as well as credit courses.

(a) The School for Continuing Education should be administered by a board consisting of the deans of the University of Saskatchewan Colleges of Medicine, Nursing, Pharmacy and Dentistry, and the deans of the health sciences and community services divisions of the Saskatchewan Institute of Applied Science and Technology.

(b) The School for Continuing Education must develop a communications network which taps the potential of such means as fibre optics, satellite systems and cellular communications.

4.57 The budget of the Health Sciences School for Continuing Education should be established on the basis of contributions by the sponsoring training institutions, grants from the major Saskatchewan health professional associations and the Department of Education, as well as enrolment fees.

Exhibit A: Physicians Licensed to Practise in Saskatchewan

	GENERAL AND FAMILY PRACTICE	CERTIFIED SPECIALISTS	TOTAL	PHYSICIAN PER POPULATION RATIO
1968	581	327	908	1:899
1975	719	414	1,133	1:810
1981	800	480	1,280	1:756
1986	899	524	1,423	1:713
1990 *	952	550	1,502	1:665

* Estimated

Sources: Data for 1968, 1975, 1981 and 1986 are from Health and Welfare Canada reports. Data for 1990 is an estimate based on College of Physicians and Surgeons of Saskatchewan mailing list.

Exhibit B: Physician per Population Ratios December 31, 1988

PROVINCE	GENERAL PRACTITIONER /FAMILY PHYSICIAN PER POPULATION	CERTIFIED SPECIALIST PER POPULATION	PHYSICIAN* PER POPULATION RATIO
Newfoundland	1:907	1:1,883	1:612
Prince Edward Island	1:1,109	1:1,880	1:697
Nova Scotia	1:936	1:1,210	1:528
New Brunswick	1:1,330	1:1,803	1:766
Quebec	1:996	1:964	1:490
Ontario	1:996	1:1,043	1:509
Manitoba	1:1,148	1:1,216	1:591
Saskatchewan	1:1,039	1:1,872	1:668
Alberta	1:1,064	1:1,346	1:594
British Columbia	1:904	1:1,063	1:489
Yukon	1:853	1:5,120	1:731
Northwest Territories	1:1,506	1:6,588	1:1,226
CANADA	1:1,001	1:1,104	1:525

* Excludes interns and residents.

Source: Physician figures from Health Information Division, Policy, Communications and Information Branch, Health and Welfare Canada.

Exhibit C:
Current Distribution of Physicians in Saskatchewan
February, 1990

	GENERAL PRACTITIONERS	RECOGNIZED SPECIALISTS	ALL PHYSICIANS
Large Urban			
Saskatoon and Regina	484	483	967
Urban			
Prince Albert and Moose Jaw	97	41	138
Communities of more than 5,000	154	23	177
Northern Saskatchewan	16	-	16
Remaining Communities	201	3	204
	952	**550**	**1,502**

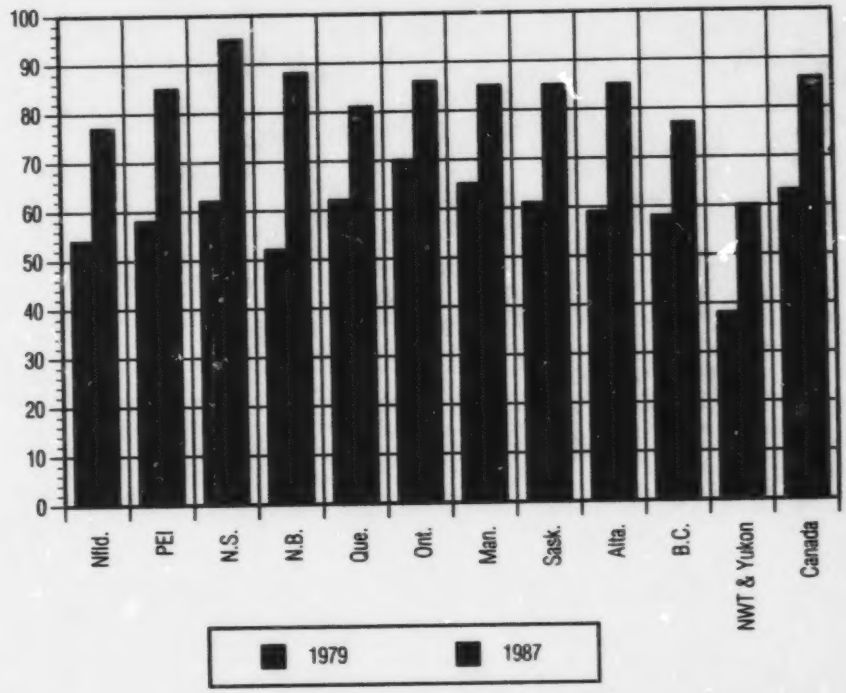
Source: College of Physicians and Surgeons of Saskatchewan Mailing List, February, 1990

Exhibit D:
Physicians by Place of Graduation
1988-89

	SASKATCHEWAN	OTHER PROVINCES	OUTSIDE CANADA
General Practitioners	35%	12%	53%
Specialists	29%	25%	46%
All Physicians	33%	17%	50%

Source: Medical Care Insurance Branch, Saskatchewan Department of Health

Exhibit E:
Ratio of Registered Nurses Employed in Nursing per 10,000 Population, Canada and Provinces, 1979 and 1987



Source: Report on Nursing Human Resources, submitted to the Conference of Deputy Ministers of Health, December 7-8, 1989 in Ottawa. Federal/Provinci
Advisory Committee on Health Human Resources, November 1988.

Exhibit F:
Educational Status of Nurses Registered in Saskatchewan

EDUCATION	**NUMBER**	**% OF TOTAL**
Diploma in Nursing	7744	82.0
Basic Baccalaureate in Nursing	943	9.9
Post-Basic Baccalaureate in Nursing	409	4.3
Post-Basic Baccalaureate in Non-Nursing	253	2.6
Masters Degree in Nursing	33	.3
Masters Degree in Non-Nursing	56	.6
Doctorate in Nursing	3	-
Doctorate in Non-Nursing	2	-
Total Number Registered as of December 31, 1989		**9443**

Note: Post-Basic Baccalaureate refers to a degree obtained after a nursing diploma.

Source: Saskatchewan Registered Nurses' Association

5. Provincial Programs in a New System

Foreword
Children's Dental Program
Saskatchewan Prescription Drug Plan
Poison Control and Drug Information Services
Laboratory Services
Saskatchewan Cancer Foundation
Saskatchewan Alcohol and Drug Abuse Services
Health Manpower Planning
Co-ordination of Government Services
Provincial Specialized Care Institutions
Non-Government Organizations
Health Analysis and Development Commission
Health Care Ethics
Exhibits

Foreword

The government of Saskatchewan plays a major role in the development of health services for the people of the province.

In recent years, changes to several provincial health programs have caused considerable controversy and debate. Changing the provincial Children's Dental Program from a school-based service to one delivered by private practice dentists has been criticized for several reasons, many centering on the issue of convenient access to services. The 1987 imposition of insurance deductibles and co-insurance charges to prescription drug users was also greeted with mixed feelings. It was feared that such changes posed a financial hardship for some citizens.

The involvement of the provincial government as the "insurer" of health services for the population will always make change to the insurance plan a matter of political debate. This is as it should be in a democratic society, because this provides the means to sensitize society and government to issues, concerns, and expectations concerning comprehensive and quality health services.

However, it is critical that decisions and directions affecting the health system should be based on objective research and proven need rather than on political considerations. The health system must be outcomes-oriented.

Modern management information technologies promise to provide decision-makers with the data they need to manage the health system effectively. The government needs to develop organizational mechanisms to make good use of existing and future information banks and to ensure that all health programs are delivered appropriately, with the correct balance between safeguarding the public interest and effective management practice.

It is particularly important that health promotion and disease prevention are seen by the government as not being the exclusive prerogative of the Department of

Health. All government departments and agencies need to look upon the development of a healthful society as something to strive for. It could be, for example, that developing programs providing for adequate standards of living in terms of accommodation or income could result in health improvements that exceed the benefits of such expenditures as X-ray machines and long-term care beds.

The Commission believes that some services now delivered by the Department of Health would be more effectively delivered by local authorities who would be somewhat distanced from provincial politics. At the same time, it believes the government must strengthen its ability to develop important policies, strategies, goals and objectives in key areas such as health manpower planning and laboratory services.

Section 5 contains ideas and recommendations for new directions in provincial health programs and services, in line with the principles outlined earlier.

Children's Dental Program

A comprehensive dental care program for children has existed in Saskatchewan since 1974. It was initially school-based, and teams of dental therapists, dental assistants and supervising dentists delivered the services. In 1987, the program was reconstituted to be delivered by private practice dentists in their own offices. It is now funded by capitation payments to the College of Dental Surgeons for each enrolled and participating child.

The change in 1987 has been severely criticized for a number of reasons:

- A perceived loss of access to dental services, particularly in rural Saskatchewan.
- Loss of classroom time for children to visit dentists' offices.
- The inconvenience of taking children for dental visits, particularly for two-career families.
- The layoffs of the school-based dental therapists.

Statistics suggest that the active participation of Saskatchewan children in the dental program has not changed significantly. Furthermore, the involvement of private practice dentists in the delivery of services to school-age children has expanded dental services to the rural population. The additional patient load has enabled dentists to open new practices in smaller communities; 37 full-time and satellite dental clinics were operating in rural communities as of March 1, 1990.

Since its inception, the dental program has contributed to increased awareness among families of the importance of good dental health, and has significantly improved the dental health of our young population.

Indications are, however, that some segments of the population are not receiving dental services, and are experiencing poor dental health. The Commission is aware, and pleased, that steps are being taken to provide services to children in the core areas of Regina and Saskatoon who are missed by the program. The need for better dental services for northern children is discussed in Section 6.

Generally speaking, the current Children's Dental Program is meeting the needs of the school-age population, though the Commission suggests the cost of the program should be carefully monitored.

RECOMMENDATIONS

5.1 The Children's Dental Program should continue to be offered under the private dental practice model for children aged 5 to 13.

5.2 Initiatives being taken by the Department of Health to provide services to children living in core areas of the major cities should be continued, and expanded as needs indicate.

5.3 To improve their accessibility to school-age children, dentists should extend their office hours to a greater extent.

Saskatchewan Prescription Drug Plan

Various presentations and the Commission's own analysis suggest that, through the Saskatchewan Prescription Drug Plan, residents of this province have better overall protection from drug costs than any other Canadians. However, there are problems that should be addressed.

Several presentations expressed concern about the inappropriate use of prescription drugs by the population as a whole, but particularly by the elderly. There was worry about the incremental risk to people when drugs are used inappropriately.

There has been a major increase in the number of prescriptions issued, a major increase in utilization, and an equally major increase in the cost to the Saskatchewan taxpayers. None of these increases can be justified on the basis of need, but unfortunately many consumers expect "a pill for every ill".

Instead of demanding more drugs, people should be encouraged to accept greater personal responsibility for their health and to become more informed consumers of health products and services.

However, public demand is only part of the problem. People can only get prescription drugs that are prescribed by a doctor and dispensed by a pharmacist. These health professionals, their associations and the colleges which train them should be challenged to face the problem of overuse, identify specific drug use problems, and develop strategies that will bring about more appropriate use.

Pharmacists have indicated they do not have adequate opportunity to use their professional knowledge concerning the appropriateness of prescriptions or dosage regimens, or make other pro-active interventions. They are trying to contribute more by implementing drug monitoring and drug information systems, providing consulting services to physicians and counselling services to patients. At the same time, they have an unhappy sense that they are becoming retailers of pre-mixed and pre-packaged drugs.

The current reimbursement system for pharmacy services penalizes the pharmacist who for professional reasons takes actions which result in a prescription not being filled. Like other reimbursement and funding systems, the system for pharmacists rewards them for activity, not necessarily for results or desired health goals.

"No sub" prescriptions continue to be a problem, though independent professional committees in Saskatchewan, Manitoba, Ontario and federally have indicated that for certain categories of drugs, the products manufactured by different approved companies are interchangeable and of equal quality and therapeutic effectiveness. This interchangeability permits tendering for high volumes of drugs and saves millions of dollars across the country.

Approximately 25% of the prescriptions written in Saskatchewan for interchangeable drugs are "no sub". This costs the drug plan an extra $3.4 million a year.

RECOMMENDATIONS

5.4 **The Saskatchewan Formulary system should continue with renewed vigor its excellent efforts to provide quality, effective and cost-efficient products and a list of interchangeable products for use by Saskatchewan residents.**

(a) The price tendering policy should be continued for all interchangeable brands. In addition, the province should negotiate prices for higher volume single supplier drugs to take advantage of volume and package size.

(b) The purchase price of the product should be listed in the Formulary.

5.5 **The Department of Health should establish a PHARMACEUTICAL PRACTICES BOARD OF SASKATCHEWAN, which would assume the combined responsibilities, roles and mandates of the Saskatchewan Formulary Committee, the Joint Committee on Drug Utilization and the Minister's Advisory Committee on the Safe Use of Drugs.**

(a) The Pharmaceutical Practices Board should consist of one representative from each of the College of Medicine and College of Pharmacy, University of Saskatchewan; the Saskatchewan Medical Association; the College of Physicians and Surgeons; the Saskatchewan Pharmaceutical Association; the Saskatchewan Registered Nurses' Association; the Saskatchewan Home Care Association; the Saskatchewan Seniors Association; the Consumers' Association of Canada, Saskatchewan Branch; and the Department of Health.

(b) Specific responsibilities of the board should be:

- (i) to use Saskatchewan's extensive drug utilization data bank for research into the appropriate use of prescription drugs. In consultation with medical and pharmacy professionals, it should recommend specific actions to ensure more appropriate use of prescription drugs.
- (ii) to identify prescribing and dispensing problems and work with the medical and pharmacy regulatory bodies to use education and regulatory measures to deal with them.
- (iii) to recommend public education programs about the benefits and risks of prescription drugs to help people make informed choices.
- (iv) to ensure the commitment of research money made during the enactment of federal Bill C-22 is fulfilled.

(c) The drug quality assessment committee should function as a subsidiary of the Pharmaceutical Practices Board.

5.6 The Pharmaceutical Practices Board of Saskatchewan should determine specific criteria to govern the circumstances in which it is appropriate to write a "no substitution" prescription, and a procedure to monitor the frequency with which these are written.

(a) The board should have the power to require physicians who frequently use this option to provide the scientific evidence or rationale for doing so.

Poison Control and Drug Information Services

According to the Saskatchewan Pharmaceutical Association, approximately 25,000 Saskatchewan residents are accidentally poisoned each year.

The Dial Access Drug Information Service was established in 1975 by the College of Pharmacy, the Saskatchewan Pharmaceutical Association, Continuing Medical Education, the College of Medicine and the Saskatchewan Prescription Drug Plan to provide drug information services to physicians and pharmacists. The number of requests it receives has steadily increased, in spite of reduced services. Apparently this program is now in jeopardy because of a lack of stable funding.

Saskatchewan has two poison control information centres located in the emergency departments of University Hospital, Saskatoon and Regina General Hospital, Regina. Each has a poison control telephone line, a poison information microfiche system, a number of reference books and a small file of relevant materials to be used in poison identification and treatment.

The Commission is advised that neither centre has the resources to provide:

- Formal poison counselling training for emergency department staff.
- Follow-up services to callers.
- Poison control educational services to clinicians and the public.
- Monitoring or evaluation of the service provided.

While the centres provide a sound basic service, their shortcomings make it evident that expanded services must be made available.

Two options exist to give Saskatchewan access to a high-quality and comprehensive poison control and information service. The first option is to greatly expand the services and expertise available within the province. The second is to consider services available outside the province.

The merit in provinces and regions sharing highly-specialized services is evident and has been noted in such studies as the *Future Directions in Health Care* report prepared by the provincial deputy ministers of health in 1988. Furthermore, since consultation and information are the basic components of a poison control program, this is an area which lends itself to service delivery at a distance.

A sophisticated toxicology centre in Calgary, Alberta is renowned for its services and expertise. Because of the efficient communications technology in existence today, this program is accessible to Saskatchewan.

RECOMMENDATIONS

5.7 **The Department of Health should develop an agreement with the Poison Control and Drug Information Service operated by Foothills Hospital in Calgary, Alberta which would provide a high-quality, sophisticated program to serve the needs of all Saskatchewan health care professionals, institutions and residents.**

(a) The resources allocated to the existing poison control centres at Regina General Hospital and University Hospital should be directed toward the cost of subscribing to this poison control service.

(b) Toll-free numbers for the centre should be widely advertised to health care givers and the public, to provide access 24 hours a day.

(c) Foothills Hospital Poison Control Centre should provide all necessary follow-up services to callers, and consultative, educational and training services to Saskatchewan clinicians and health personnel.

Laboratory Services

Laboratory services in the province are provided by a variety of hospitals and private laboratories, as well as the Provincial Laboratory.

The Provincial Laboratory's role, since its beginning, has primarily been the provision of laboratory services and tests. While the volume of service it provides has increased considerably over the years, its mandate has remained unchanged.

In recent years, private laboratory services have proliferated in the province, particularly in the large urban centres, and the costs and utilization associated with them have risen dramatically.

The delivery of laboratory services lacks organization and as a consequence, their availability varies considerably, particularly in rural areas.

A number of factors suggest the appropriateness and potential of a systematic approach to the delivery of laboratory services in Saskatchewan:

- The new division system and categorization of health care facilities is conducive to changing the laboratory service delivery structure.
- The recent Lone-Warren report on laboratory services in Saskatchewan made a number of recommendations about quality assurance, licensing and utilization.
- Following up the Lone-Warren report, the Department of Health has introduced a laboratory licensing program with quality assurance and management of the future growth and distribution of laboratory services as its main components.
- A number of laboratories exist throughout the province providing a base on which to build and improve services.

It has come to the attention of the Commission that some private laboratories have engaged in a considerable amount of aggressive marketing practices which encourage inappropriate utilization and raise ethical considerations. This gives rise to the question of whether any laboratory promoting such activity belongs in a publicly-funded health care system.

RECOMMENDATIONS

5.8 The Department of Health must develop a provincial system of laboratory services which defines the scope of services to be provided in various settings and levels throughout the province and which reflects the health services division structure.

(a) Three categories of laboratory services should be established:

  (i) Category 1 should identify base hospital laboratories as the focus for the provision of special services, with the "Centres of Excellence" concept being the mechanism of choice.
  (ii) Category 2 should identify the range of services available at division hospitals and an identified number of services which would be more appropriately delivered at that level should be transferred from the base hospitals and the Provincial Laboratory.
  (iii) Category 3 should identify the services which would be available in community hospitals, generally involving routine and basic tests.

(b) The role of the Provincial Laboratory must be reviewed and its mandate redefined to complement and supplement the roles of hospital-based laboratories.

(c) Sophisticated communications technology should link all laboratories to facilitate a more comprehensive and responsive service at all levels.

5.9 A LABORATORY SERVICES REVIEW BOARD should be established by the Minister of Health to license medical laboratories; set, monitor and control standards; provide consultation and advice to laboratories; and co-ordinate services.

(a) The board should be comprised of representation from the Saskatchewan Health Care Association, Saskatchewan Society of Medical Laboratory Technologists, College of Physicians and Surgeons, Saskatchewan Medical Association, Department of Health, and the public at large.

5.10 The methodology and usefulness of laboratory services done by physicians in their offices, and those performed on a referral basis, must be reviewed by the Laboratory Services Review Board, and examined with a view to introducing quality control and reimbursement on a cost basis only.

5.11 In order to inject accountability and monitoring into the laboratory system, all laboratories in the province must regularly provide the Laboratory Services Review Board with physician profiles as to lab ordering patterns and utilization of such services.

5.12 Methods should be established to require most services provided by private laboratories to become the responsibility of hospital-based laboratories, and no new private laboratories should be licensed until a final plan is adopted.

Saskatchewan Cancer Foundation

The Saskatchewan Cancer Foundation is governed by a board appointed by the Lieutenant-Governor. It receives provincial funding but operates as an autonomous body.

Treatment is provided out of two clinics. The Allan Blair Memorial Clinic in Regina is located at Pasqua Hospital and the Saskatoon Cancer Clinic is located at University Hospital.

Steps are needed to ensure greater co-ordination between the clinics and their host hospitals, increased services in rural Saskatchewan and increased rural input into decision-making. These objectives are attainable, given the following circumstances:

- The clinics and the hospitals have demonstrated the ability to work together co-operatively.
- The proposed division governing structure provides a mechanism for local input.
- The proposed categorization of health care facilities in divisions lends itself to the delivery of expanded services in rural Saskatchewan.

The Commission noted with special interest the efforts of the Saskatchewan Cancer Foundation to encourage various outreach programs for the convenience of patients. These developments require special attention to ensure that Saskatchewan cancer programs, which are recognized worldwide, maintain the highest quality of treatment.

RECOMMENDATIONS

5.13 The Saskatchewan Cancer Foundation should maintain its current autonomous operating status and its reporting relationship with

the provincial government, as legislated by The Saskatchewan Cancer Foundation Act.

5.14 **The name of the Saskatchewan Cancer Foundation should be changed to the SASKATCHEWAN CANCER TREATMENT AND RESEARCH FOUNDATION to more accurately reflect its mandate and function.**

5.15 **The Saskatchewan Cancer Treatment and Research Foundation should be governed by a 10-member board appointed by the Lieutenant-Governor, with seven representatives nominated by the Division Council Co-ordinating Board and one representative nominated by each of the College of Medicine, the College of Physicians and Surgeons and the Saskatchewan Registered Nurses' Association.**

(a) Board members should be appointed for three-year terms, and be eligible for reappointment for a second term.

(b) The chairperson should be appointed by the board from among its members for one-year terms.

5.16 **In Regina and Saskatoon, joint planning committees consisting of administrative and medical representatives from the Allan Blair Memorial Clinic and the three Regina hospitals, and the Saskatoon Cancer Clinic and the three Saskatoon hospitals, respectively, should be established to facilitate the joint planning and co-ordination of cancer clinic operations.**

5.17 **The Saskatchewan Cancer Treatment and Research Foundation should expand its chemotherapy services to division hospitals, provided appropriate personnel and facilities are available, to enable cancer patients in rural Saskatchewan to obtain chemotherapy treatments nearer to home.**

5.18 **The Saskatchewan Cancer Treatment and Research Foundation must maintain its strong commitment to the highest quality of cancer treatment and must, as required, constantly monitor and enhance the quality control of treatment, as well as the registration and follow-up of cancer patients.**

Saskatchewan Alcohol and Drug Abuse Services

Alcohol and drug abuse services in the province are operated by the Saskatchewan Alcohol and Drug Abuse Commission (SADAC) which is run by a government-appointed board. The Commission is funded by the provincial government, and officially operates independently as a third-party agency; in reality, it functions in many respects as a branch of the Department of Health.

Alcohol and drug abuse services have received considerable positive attention in recent years, particularly with respect to funding. Many good initiatives have resulted; unfortunately, major program changes and additions don't always directly respond to community needs and priorities.

Generally speaking, the services provided by SADAC are satisfactory. However, the issues of status, responsiveness to community needs and objectivity in decision-making need to be addressed. The key to resolving all three lies in confirming SADAC's status as an independent agency.

Three factors suggest a readiness for movement in this direction, and its appropriateness:

- A sound program base, and high-quality and knowledgeable staff.
- Existing legislation (The Saskatchewan Alcohol and Drug Abuse Commission Act) which stipulates the Commission's autonomy.
- The proposed new division governing structure which is conducive to local input and involvement.

RECOMMENDATIONS

5.19 The status of the Saskatchewan Alcohol and Drug Abuse Commission should be clarified and confirmed through modifications to The Saskatchewan Alcohol and Drug Abuse Commission Act which ensure a greater degree of independence in the management and operation of its programs, and its name should be changed to the SASKATCHEWAN ALCOHOL AND DRUG ABUSE FOUNDATION to reflect this re-affirmed autonomy and new operating status.

5.20 The Saskatchewan Alcohol and Drug Abuse Foundation should be governed by a 14-member board appointed by the Lieutenant-Governor, with seven members nominated by the Division Council Co-ordinating Board, at least one of whom represents the northern division councils; two representatives nominated by Alcoholics Anonymous organizations; and one representative nominated by each of the Saskatchewan Teachers' Federation, the College of Physicians and Surgeons, the Saskatchewan Mental Health Association, the Saskatchewan Pharmaceutical Association and P.R.I.D.E.

(a) Board members should be appointed for three-year terms, with eligibility for reappointment for a second term.

(b) The chairperson should be appointed by the board from among its members for one-year terms.

5.21 The regional boundaries for the delivery of alcohol and drug abuse services should be changed to correspond to those established for the health services divisions.

5.22 Employees of the Saskatchewan Alcohol and Drug Abuse Commission should become employees of the Foundation and their employment should be independent of the provisions of The Public Service Act and regulations.

(a) The transfer of Commission employees to the Foundation should occur without loss of employment benefits.

5.23 An ALCOHOL AND DRUG ABUSE COMMITTEE should be established in each health services division to maximize community input into program planning and to facilitate integration of alcohol and drug abuse services with division programs.

(a) The committee should include a representative of the Saskatchewan Alcohol and Drug Abuse Foundation, representatives of professional and advocacy groups and citizens at large.

(b) The committee should be appointed by the division council in consultation with local, professional and advocacy groups.

(c) Reporting to a designated division councillor, the committee should provide input and advice on program planning based on community needs.

(d) Based on input from the advisory committee the division council should liaise with the Saskatchewan Alchohol and Drug Abuse Foundation on matters relating to alcolohal and drug abuse services and needs at the community level.

Health Manpower Planning

Saskatchewan is facing increasing problems with health manpower. General practitioners are poorly distributed, and there is a shortage and maldistribution of specialists. A shortage of nurses is emerging. There is already a significant shortage of physical therapists and occupational therapists. Northern Saskatchewan is experiencing major shortages in almost every health profession.

Co-ordination between the health system and the education system is relatively weak. Nursing enrolments were cut back at the Saskatchewan Institute of Applied Science and Technology at a time when a shortage of nurses is threatened. The curriculum for the College of Nursing has been significantly changed without sufficient consultation with major employers. Follow-up and communication with Saskatchewan graduates and bursary recipients in the health field are minimal, thus contributing to a lack of information about opportunities in Saskatchewan.

Not enough priority is given to continuing education for health professionals, despite the belief that distance education programs can greatly improve professional competence, productivity and satisfaction.

Health manpower planning is an important management challenge if we are to avoid serious manpower shortages in the health system.

RECOMMENDATIONS

5.24 The Department of Health should create a HEALTH MANPOWER BRANCH which would work closely with division councils, health care professionals and other health care providers in developing and maintaining a manpower plan which ensures an adequate supply and distribution of health and medical professionals in the province.

(a) The Branch should develop, monitor and maintain an up-to-date comprehensive inventory of health manpower.

(b) The Branch should develop sophisticated manpower forecasts and initiate strategies to deal with projected shortfalls or surpluses.

(c) The Branch should consult with the Department of Education and individual training institutions regarding education and training programs, curriculum, clinical practicums and continuing education, and submit its plans for education bursaries, program modifications and expansions, with requests for changes, to the Deputy Ministers of Health and Education.

(d) The Branch should advise the Minister of Health on collective bargaining issues that affect manpower planning, and on legislation and regulatory issues related to health professions.

5.25 Bursary and other education assistance programs sponsored by the Department of Health should be pro-active in providing ongoing contact with and support to bursary recipients during their training, contributing to interest in employment and practice opportunities in the Saskatchewan health care system.

5.26 Monitoring and communication systems should be developed jointly by the Health Manpower Branch, Department of Health and the various educational institutions to facilitate ongoing contact with graduates of Saskatchewan health care programs.

(a) Such mechanisms should be oriented to informing graduates of employment and practice opportunities in Saskatchewan and generally to maintaining links between graduates and the health care system in the province

Co-ordination Of Government Services

A number of presentations to the Commission expressed concern about fragmentation of responsibility among and within different government departments. Particular reference was made to "total services packages", such as housing for individuals with special needs. Responsibility for various aspects of the housing program lies with the Departments of Social Services, Health, and the Saskatchewan Housing Corporation.

The Commission was also informed that the regulations on accommodations, particularly group homes, are significantly different for the mentally handicapped than for people suffering from physical or multiple handicaps, despite the similarity in requirements. Again, this is primarily because different departments have responsibility for what are basically the same services.

Co-ordination of support services is also a problem because of the different jurisdictional responsibilities that exist for different groups. It has been said, for example, that home care, which is the general responsibility of the Department of Health, is rarely provided to mentally handicapped persons, whose needs are primarily the responsibility of the Department of Social Services.

Co-ordination becomes even more complicated when services to special groups extend beyond health care. Education and rehabilitation, for example, are the responsibility of yet other agencies such as the Department of Education.

Mechanisms need to be put in place to permit greater co-ordination and consistency among government agencies whose programs and services are related.

RECOMMENDATIONS

5.27 A SOCIAL POLICY SECRETARIAT should be established with representation from the Departments of Health, Social Services, Education, Human Resources, Labor and Employment, the Saskatchewan Alcohol and Drug Abuse Foundation, the Saskatchewan Housing Corporation and the Saskatchewan Family Foundation, to facilitate communication, co-ordination and planning of common programs and services.

(a) Secretariat members should be senior department officials appointed by their respective deputy ministers.

(b) The Secretariat should review and make recommendations to the deputy ministers of the social policy departments on issues, policies and priorities of common interest, including staffing and financing requirements, program components and standards, and funding of non-government organizations (NGOs). (Refer to Recommendation 5.31).

(c) The Secretariat should report annually to the Planning and Priorities Committee of Cabinet.

(d) The Secretariat should establish a method of communicating with the Division Council Co-ordinating Board, to advise, share information, and consult on matters which affect services provided by division councils.

5.28 Overall responsibility for respite and community-based residential programs for special needs groups, now administered by the Departments of Health and Social Services, should be concentrated in the Department of Health, and responsibility for local management and delivery of these programs transferred to the division councils.

(a) The Department of Health should have responsibility for licensing of and estabishing provincial operating standards and basic funding criteria for group homes.

(b) On the basis of assessed community needs, division councils should provide respite and other supportive living services through their home care programs, and fund group homes to assist individuals with special needs to remain in the community.

(c) The Department of Social Services should continue to provide counselling and other social programs required by special needs families or individuals living in the community.

(d) Subsidized housing which provides minimal or no supervised or supportive living services should continue to be the responsibility of the Saskatchewan Housing Corporation.

Provincial Specialized Care Institutions

With a population of only one million, it is difficult for Saskatchewan to offer specialized care services on a local or even a regional basis; specialized professional expertise is required but the number of people requiring the service is relatively few.

Certain specialized care services must be developed to serve the population as a whole.

Facilities such as the Wascana Rehabilitation Centre, the Parkridge Centre, the Valley View Centre and Saskatchewan Hospital North Battleford must be viewed as important and unique provincial resources.

These specialized care facilities must be administered outside of the proposed division organization structure.

RECOMMENDATIONS

5.29 Specialized care institutions which offer programs and services beyond the mandates of supportive care centres and hospitals and which serve the total population must be operated directly by the Government of Saskatchewan.

(a) Such institutions should include the Wascana Rehabilitation Centre, Parkridge Centre, Saskatchewan Hospital North Battleford and the Valley View Centre.

(b) Each of these institutions should have a management board of eight to 10 people appointed by the Lieutenant-Governor, including at least two nominees of the Division Council Co-ordinating Board.

5.30 In order to provide a continuity in the supportive living services offered within institutions and in the community, and to facilitate a continuum of care, responsibility for the Valley View Centre should be transferred to the Department of Health from the Department of Social Services.

(a) Social work and other support programs and services offered for the mentally handicapped through the existing Community Living Program of the Department of Social Services should continue to be the responsibility of that department.

Non-Government Organizations (Social Policy Sector)

A number of non-government organizations (NGOs) receive provincial funding to provide a wide variety of services to and for the public. For example, the Saskatchewan Health-Care Association, the Saskatchewan Association of Special Care Homes and the Saskatchewan Home Care Association provide important support services for hospitals, long-term care homes and home care boards. The Saskatchewan Alzheimer's and Related Diseases Association provides support services directly to individuals and families affected by such diseases.

NGOs provide an important supplementary service in the health care system, and receive a considerable amount of funding each year. The Department of Health alone targeted almost $10 million for such organizations in 1988-89. In the social policy sector, the Saskatchewan Alcohol and Drug Abuse Commission and the Departments of Social Services, Human Resources, Labor and Employment, Justice and Education also fund NGOs; together, the six government agencies budgeted $53 million for this area.

Unfortunately, there is no systematic approach to funding and liaising with NGOs, which results in confusion and a lack of co-ordination and efficiency. Particular concerns relate to:

- The lack of funding criteria, with many funding decisions based on historic patterns and lobbying tactics.
- The lack of accountability by funded NGOs.
- The lack of evaluation of NGO programs and services.
- The lack of communication and planning between departments which frequently fund the same NGOs.
- Confusion among NGOs about appropriate channels for communication and information, and lack of a mechanism to provide guidance and assistance to them.
- Duplication of administrative structures among NGOs which provide similar services.

A system is needed which recognizes the important contribution of NGOs to the health system, improves co-ordination and accountability, and provides consistent funding criteria.

RECOMMENDATIONS

5.31 A major function of the proposed Social Policy Secretariat should be to facilitate co-ordination, consistency and accountability in provincial funding of non-government organizations in the social policy sector.

(a) Specific objectives and responsibilities relating to non-government organizations should include:

- Development of a process which establishes provincial funding criteria, and a monitoring and evaluation system.
- Determination of the annual distribution of funds to provincial-level NGOs funded by more than one government department.

- Facilitation of co-operation and co-ordination between NGOs and government departments.
- Consultation and guidance to NGOs about efficiencies and proposals about sharing of administrative functions.

5.32 Division councils should be responsible for funding local health-related non-government organizations in their divisions, and funding decisions should be in accordance with provincial criteria established by the Social Policy Secretariat.

5.33 Each government department in the social policy sector should designate a single official or unit as the primary contact for non-government organizations to facilitate assistance to and communication with them.

(a) This single official or unit should also serve as the primary contact for division councils on matters relating to local-level NGOs.

Health Analysis and Development Commission

Study of the health care system in Saskatchewan suggests that insufficient attention is being given to measuring the results of the activities and programs which are undertaken. Indeed, this has been suggested as characteristic of the entire Canadian health care system.

Various reports, presentations and analyses suggest resources are sometimes allocated without sufficient consideration of the benefit that could be derived from such spending and the cost-effectiveness of the initiatives.

Briefs presented to the Commission identified the following concerns:

- Insufficient constructive use is made of Saskatchewan's extensive database, particularly as it relates to drug utilization and use of professional services.
- Decisions on construction and renovation of facilities are not based on a co-ordinated long-term plan which identifies criteria, targets and needs.
- Resource allocation is determined without necessary in-depth analysis of all relevant factors.
- Historic delivery patterns, provider self-interest and political considerations frequently determine the priorities which are established and the program decisions made.
- Outcomes-oriented information is lacking on various modalities of treatment.

The Commission considers the following recommendations some of the most important in its report. Without such a development there is a very great danger the new changes recommended may, in time, become inflexible and out of touch with new developments and realities that are bound to occur.

These recommendations will not be inexpensive but the returns on such an investment will be many-fold.

RECOMMENDATIONS

5.34 The Government of Saskatchewan should establish an autonomous HEALTH ANALYSIS AND DEVELOPMENT COMMISSION under a special act of the legislature to monitor and analyse health programs and practices, determine their effectiveness and efficiency, and recommend policies to the government and division councils.

(a) The Commission should study health delivery systems in other jurisdictions, analyse program delivery systems, and comment on the effectiveness and appropriateness of initiatives in the health services divisions.

5.35 The Health Analysis and Development Commission should consist of 10 members and a chairperson all selected by a special committee and appointed by the Lieutenant-Governor.

(a) An eight-member selection committee should be appointed, with the Chief Justice of the Province of Saskatchewan as chairperson, and made up of the Presidents of the Universities of Saskatchewan and Regina, the Saskatchewan Federation of Labor, the Saskatchewan Chamber of Commerce, the Saskatchewan Association of Rural Municipalities, the Saskatchewan Urban Municipalities Association and the Consumers' Association of Canada, Saskatchewan Branch.

(b) The selection committee should submit the list of 10 members and the chairperson to the Lieutenant-Governor who would officially appoint the Commission.

(c) Members should be appointed for three-year terms on a rotating basis, with one-third of the membership appointed each year.

(d) The chairperson should be appointed for a three-year term.

(e) Members should be permitted to be re-appointed for two terms.

5.36 The Health Analysis and Development Commission should be responsible to the Saskatchewan legislature, and should present to

the Legislative Assembly a formal annual report commenting on the health care system in the province.

(a) The purpose of the report should be to indicate the status of health care services, the outcomes which were achieved, potential dangers or crises which may develop, and overall directions for the future.

5.37 **To carry out its mandate to the fullest degree, the Health Analysis and Development Commission must establish a Health Analysis and Development Centre which would study issues such as quality assurance, health care utilization, cost effectiveness and technology assessment.**

(a) Specifically, the Commission must monitor, assess and report on the performance of the health system with the following focus:

(i) the effective use of human and financial resources.
(ii) the effectiveness of the delivery systems for the Saskatchewan setting.
(iii) the unmet health care needs of various groups in society.
(iv) the degree to which decisions and policies result in identifiable outcomes.

(b) Specific research in these and other areas would be undertaken on initiatives from within the Commission or on the request of division councils, the Division Council Co-ordinating Board or the Department of Health, with the Commission itself determining the priorities of such research.

(c) The Commission would be expected to be knowledgeable concerning similar projects occurring in Canada, as well as other countries, and must promote the sharing of such studies and information.

(d) The Government of Saskatchewan must make a commitment to establish a budget which will permit the appointment of a nucleus of staff with research, administrative and support skills to ensure the Commission's mandate is fulfilled and a continuity of service is maintained.

(e) Consideration should be given to locating the Centre near Innovation Place on the University of Saskatchewan campus.

5.38 **The Health Analysis and Development Commission must establish a formal liaison with the Division Council Co-ordinating Board and the Department of Health so it can share its research and information about the delivery of health care services throughout the province and in various divisions.**

(a) The Commission should meet at least annually with the Division Council Co-ordinating Board and the Department of Health to discuss health care issues and concerns identified by council and department representatives and to report on studies concluded by the Centre.

Health Care Ethics

During its public hearings and its research, the Commission heard many presentations that touched on the question of ethics in the health care system, though they might not have been labelled that way. Commissioners gave considerable thought to this subject.

Ethics can be described as a system of principles or standards which reflect human nature and human society, and govern conduct. In the case of health care, these principles are normally interpreted as an obligation to provide the best possible holistic care and to maintain an honest relationship with patients, fellow health care workers and society at large, respecting the consciences of all concerned.

In a rapidly changing and complex world, it is often difficult to decide which actions are "right" and which are "wrong", for a great deal depends upon individual circumstances and the value systems of patients, families and caregivers. There is a need to refine our ethical thinking in this province to help educate modern society on key principles of ethical decision-making.

There is the question of giving people choices in their care, and informing them about options. Perhaps most important, there is the need for public awareness of these matters.

The Charter of Rights and Freedoms is focusing attention on such ethical issues as a patient's right to refuse treatment and the justification for the physical restraint of patients.

New medical technologies in the areas of life support, reproduction and genetic screening raise a number of ethical issues. For example, how does a hospital or a physician determine which patients are given priority for organ transplants? Determinations based upon age or "quality of life" considerations may run contrary to the Charter. The health care system is having real difficulty in dealing with experimental treatments which raise individual hopes even when the probability of survival is low and costs to taxpayers are extraordinarily high. Whose wishes prevail in a technological age when patients can be kept artificially 'alive' for prolonged periods? Who decides when death has occurred or should be allowed to occur?

For this Commission, looking at a new health care system for a small province with a big reputation in health matters and big expectations among its people, certain ethical issues loomed large. For example, how long should life be prolonged, under what circumstances and why? Who decides, when it may be a question of quantity of life versus quality of life? Some people, if asked, might prefer to die as painlessly as possible at home, without extraordinary efforts to prolong their lives. There are questions about organs for transplant, about the use of fetal tissue, about 'living wills'. There is the whole matter of deciding what share of our health care resources we want to allocate to extending life when it is a question only of life extension.

The matter of "ethical practices" can become confusing when put into the Canadian health care setting. "The best possible care" may be taken to be synonymous with "very expensive care"; since resources are limited, more for some may mean less for others. "Honest relationships" are difficult in this age of increasing litigation, high consumer expectations and a competitive business environment.

Many hospitals already have or are planning to establish ethics committees. It is important these committees do not operate only after an ethical decision has been made at the bedside, but that physicians, other health care professionals and members of a patient's family know they can approach the committee beforehand, and that the committee informs caregivers by means of regular communications.

The Commission hopes that public response to and examination of this report will include consideration of these ethical questions. But it also wants to urge action in this crucial area.

RECOMMENDATIONS

5.39 The Saskatchewan Department of Health should join with the Departments of Health in Manitoba and Alberta to establish a PRAIRIE HEALTH CARE ETHICS CENTRE for the purposes of research, study, analysis, proposing policies, developing information and educating the public in the field of ethics.

(a) The Prairie Health Care Ethics Centre should be funded by the three provinces equally to ensure it has the revenues necessary to carry out its mandate.

(b) It should be a resource for ethics forums and committees in the three provinces, providing literature and speakers to professional and hospital ethics committees and the general public, gathering and disseminating information and research in the ethics field, and generally working to increase people's sensitivity in this area.

(c) It should examine such subjects as cost-quality tradeoffs, durable powers of attorney, and living wills.

5.40 A PROVINCIAL FORUM ON HEALTH CARE ETHICS should be established in Saskatchewan to develop provincial principles and guidelines on health care issues, to provide the opportunity for discussion, and to serve in an advisory capacity to government and local authorities.

(a) The forum should include representatives from the following groups: university faculties of medicine, base (teaching) hospitals, professional physician and nursing bodies, law schools, university philosophy departments, and the religious community.

5.41 Each division council must establish a HEALTH CARE ETHICS ADVISORY COMMITTEE to develop strategies for interpreting and implementing provincial guidelines in this field, and to identify and advise on issues of particular significance to the division.

(a) The health care ethics advisory committee should include representatives of physicians, nurses, the religious community, workers in community-based programs, and members of the public.

(b) It should act as a resource for hospitals, supportive care centres and community-based programs.

(c) Individual ethics committees must be established at base hospitals and should have as their core members representatives of the medical, nursing and social work professions, ethicists and members of the religious community.

Exhibit A:
Children's Dental Program Statistics

PROVINCIAL STATISTICS

Year	Children Eligible	Children Enrolled	% Enrolled	% Receiving Service	% of Enrolled Rec. Service	% of Eligible Rec. Service	Ages Included
1981-82	157,742	131,522	83.4%	120,510	91.6%	76.4%	4 - 13
1982-83	142,009	122,040	85.9%	117,859	96.6%	83.0%	5 - 13
1983-84	139,624	122,141	87.5%	118,993	97.4%	85.2%	5 - 13
1984-85	140,718	124,195	88.3%	121,216	97.6%	86.1%	5 - 13
1985-86	141,110	125,499	88.9%	122,645	97.7%	86.9%	5 - 13
1986-87	140,375	126,034	89.8%	123,198	97.7%	87.8%	5 - 13
1987-88	141,722	125,630	88.7%	114,842	91.4%	81.0%	5 - 13
1988-89	143,981	130,690	90.8%	119,792	91.7%	83.2%	5 - 13

RURAL/URBAN STATISTICS
1988/89 PROGRAM YEAR

	(Percentage)		
	Urban	Rural	Total
Eligible Children Enrolled	89.5%	92.0%	90.8%
Enrolled Children Receiving Services	89.6%	93.6%	91.7%
Eligible Children Receiving Services	80.2%	86.1%	83.2%

Source: Medical Care Insurance Branch, Saskatchewan Department of Health.

Exhibit B:
Use of Prescription Drugs in Saskatchewan

	PRESCRIPTIONS		POPULATION	
YEAR	Number Written	Per cent Change	Number Eligible	Per cent Change
1977-78	3,708,598		922,536	
1980-81	4,187,621	+12.9%	939,760	+1.8%
1983-84	4,882,285	+16.6%	968,111	+3.0%
1986-87	5,714,957	+17.1%	989,912	+2.3%
1989-90*	5,350,000	-6.4%	976,100	-1.4%

* Estimated

Source: Saskatchewan Prescription Drug Plan Reports.
The 1989-90 figure is an estimate made by the Commission based on preliminary data.

Exhibit C:
Laboratory Services Payments
(to Resident Physicians)

YEAR	SERVICES	PAYMENT
1984-85	2,419,900	$10,474,000
1985-86	2,676,500	$12,080,000
1986-87	2,808,000	$13,083,000
1987-88	2,753,200	$13,547,000
1988-89	2,868,700	$14,760,000

Source: Medical Care Insurance Branch, Saskatchewan Department of Health

Exhibit D:
Funding to NGOs in Social Policy Sector

DEPARTMENT	1988-89 ESTIMATES
HEALTH	$9.6 M
* SADAC	$9.0 M
SOCIAL SERVICES	$30.0 M
** HRLE	$2.8 M
JUSTICE	$.2 M
EDUCATION	$1.4 M
TOTAL	**$53.0 M**

* SADAC Saskatchewan Alcohol and Drug Abuse Commission

* HRLE Human Resources, Labor and Employment

Source: Information provided by the named Departments.

Exhibit E:

EXCERPT FROM APPENDIX K
'TOWARDS A NEW BEGINNING'
REVIEW OF THE COLLEGE OF MEDICINE
UNIVERSITY OF SASKATCHEWAN
MARCH 1989

A HEALTH CARE ANALYSIS AND INTELLIGENCE CENTRE

KERR L. WHITE, M.D.
1988

Objectives

The Centre should undertake Research and Development directed at improving health services for residents of Saskatchewan and adjacent provinces (? and states). As such, it should conduct analyses, demonstrations, and evaluations on behalf of the University of Saskatchewan, and the Saskatchewan Department of Health, other universities and educational institutions, other Provincial and local health departments, teaching and other hospitals, public, private and voluntary organizations and institutions concerned with issues of health broadly defined. Data from Saskatchewan and adjacent jurisdictions, as well as national data and appropriate data from other countries, should be used and both continuing and *ad hoc* surveys and studies conducted as required.

The Centre should be an independent and impartial source of intelligence and information about the health problems and needs of the populations served and about the relative benefits, risks and costs associated with individual and collective interventions directed at improving health status. Among the analytical and technical skills that will be employed by the Centre's multidisciplinary staff are: clinical epidemiology, cost-effectiveness studies, cost-benefit analysis, decision-analysis, evaluation research, quality assurance, risk management, surveillance and technology assessment.

Governance

Policies and priorities for the Centre should be determined by a small Board with representatives of the University, the Saskatchewan Health Department, both teaching and community hospitals and a majority of public representatives. To the extent that jurisdictions adjacent to Saskatchewan are involved with the work of the Centre, they also could be represented on the Board. The Director of the Centre would report to the Board and would have both a faculty appointment in the University of Saskatchewan and a staff appointment in the Saskatchewan Department of Health. Administratively the Centre would be attached to the Office of the Dean of the College of Medicine.

Staff

There should be a core staff consisting initially of:

Faculty Personnel*

- 2 Clinical Epidemiologists
- 1 Health Economist
- 1 Health Statistician
- 1 Medical Sociologist

*The Centre's Director might be any one of these individuals.

Support Personnel

- 2 RN Surveillance/Survey Interviewers
- 3 Research Associates/Assistants (Master's level)
- 1 Systems Analyst/Programmer
- 3 Secretaries
- 1 Word Processor/Typist

Financing

The most rational method of supporting the Centre is that employed by many industries, i.e. allocation of a percentage of total revenues for Research and Development. Biomedical and behavioral research *per se* is largely funded from Federal sources, but Health Services and Related Research and Analysis, bearing as it does on the delineation and evaluation of cost-effective science-based services, needs to be funded largely at provincial and local levels. The combined expenditures for the Medical Care Insurance Commission and the Hospital Services Plan in 1986 amounted to about $663M. An allocation of about 0.1% of this amount annually should provide the basic funding of about $700,000 annually for the Core Staff listed above. The Health Care Financing Administration in the U.S.A. allocated 1% for R & D annually.

Exhibit F:
New Provincial Agencies

PROPOSED AGENCIES	**REPLACED BY NEW AGENCY**
Saskatchewan Medical Transportation Authority	Ambulance Advisory Committee
Provincial Hospital Utilization Management Committee	Standing Committee on the Patterns of Health Service Usage
Pharmaceutical Practices Board of Saskatchewan	Formulary Committee Joint Committee on Drug Utilization Minister's Advisory Committee on the Safe Use of Drugs
Nursing Education Council	Minister's Advisory Committee on Nursing
Social Policy Secretariat (Interdepartmental)	Social Policy Secretariat (Executive Council)
Saskatchewan Mental Health Commission	
Health Analysis and Development Commission	
Laboratory Services Review Board	
Physician Services Review Panel	
Prairie Centre for Health Care Ethics (Interprovincial)	

6. Better Health For Northern Residents

Foreword
Geographic Divisions
Governing Structure for the Divisions
Mandate of the Health Services Division Councils
Role of Northern Health Services Branch
Health Care Facilities
Community-Based Services
Medical Transportation Services
Medical Services
Health Professional Training for Northerners
Staff Recruitment and Retention
Special Needs Programs
Co-ordination Among Provincial Agencies
Federal/Provincial Roles
Exhibits

Foreword

For purposes of this report, Northern Saskatchewan refers roughly to the northern geographic half of the province, currently considered to be within the Northern Administration District.

A number of factors distinguish the North from the rest of the province, factors which make it special and interesting but also pose serious and unique problems in health care delivery. In developing future directions and initiatives in northern health care, it is important to understand the character of the North and why special considerations and solutions must be sought.

The most obvious element differentiating the North from the south is, of course, its geography. The North is characterized by a number of widely dispersed, relatively small communities, most of them long distances apart. Many communities are isolated, with water or air the only transportation links.

The northern culture is also unique, predominantly founded on native tradition. This difference extends to individual communities, which reflect the different cultures and languages of the Cree and Chipewyan ancestries.

The third major factor differentiating the North is its economic situation. Most communities lack meaningful economic opportunities and development; consequently, unemployment and poverty are pronounced. Unemployment rates range from 50% in La Ronge to 90% in La Loche, a situation that leads to hopelessness among young northerners and contributes to excessive high school dropout rates.

Equally as pronounced as the geographic, cultural, and economic differences from the south is the difference in the health status of northern residents, and of the availability and accessibility of health services.

In fact, the health problems of northern residents are in many ways not unlike those found in Third World countries. Specific problems faced in the North today include:

A high incidence of infectious diseases, including respiratory infections, tuberculosis, middle ear disease and sexually-transmitted diseases.

A high incidence of alcohol and drug abuse which contributes to a high incidence of violence.

A birthrate which is at least double that of the south, and a shockingly high infant mortality rate - 15.4 per thousand live births in 1986. There are many reasons for this mortality rate, including circumstances which create poor health and pre-natal practices among young women. Furthermore, economic circumstances frequently make it impossible for mothers to adequately provide for the basic needs of the newborn.

A high incidence of single parent families.

A lack of proper nutrition.

A lack of hygienic sewer and water conditions, and of a good-quality food supply.

Northern Saskatchewan's health problems are compounded by health care services which fall considerably short of those found in the south.

Services are fragmented among a number of agencies, and health care seriously lacks planning, co-ordination, continuity and consistency. All levels of government - local, provincial and federal - assume responsibility for certain health care services. Approximately one-third of the northern population is status Indian and the federal government is responsible for providing health services to them. The provincial government is responsible for providing health services for the rest of the population, with some local authorities directly delivering selected services in their communities.

The lack of community input into planning, decision-making and delivery is particularly obvious.

Examples of the shortcomings of health care services include the following:

The ratio of physicians to population is approximately one-third of that in the south.

The ratio of professional staff such as nurses, mental health workers and home care workers is also considerably lower than in the south and professional services such as nutrition and physical therapy are almost non-existent.

Specialized acute care services are basically non-existent.

Long-term care beds are not available in the vast majority of communities.

The availability of home care programs is minimal.

Except for La Ronge, there is no regular and systematic ambulance service.

An effective health promotion and illness prevention program is lacking.

Furthermore, almost all the health care professionals serving the North are recruited from outside Northern Saskatchewan, and frequently are unfamiliar with northern culture and society.

Despite the inadequacies of the health care system and the cultural and communication differences, however, northern health staff must be commended for their commitment and the quality of service they provide.

It is evident from the presentations made to the Commission and from the information compiled that new approaches must be taken to the delivery of northern health services.

Northerners need and expect greater access to quality health services.

Furthermore, northern residents are expressing increasing concern about their lack of involvement in health care programming, and are pointing out their readiness to assume a greater responsibility for the delivery of services.

The following chapters and recommendations attempt to address the special circumstances and needs of the North. It must be emphasized, however, that health issues are only a symptom of a much larger and complex problem.

While the Commission can recommend ways to improve the health system, for success truly to be achieved, major steps have to be taken to deal with the much larger issue of improving the economic and social conditions in the North.

Furthermore, regardless of the initiatives proposed and implemented in the North, the onus will lie with individual northern communities to work together co-operatively to achieve satisfactory outcomes.

Geographic Divisions

Certain factors suggest it would be appropriate to divide the northern part of Saskatchewan into health care divisions for the purpose of delivering services. These factors include the following:

Some communities relate more naturally to each other due to such considerations as geographic features, transportation links, historical identity and cultural dimensions.

A considerable shift is occurring in the status and non-status designation of native residents, resulting in far more interdependency between status and non-status communities and an increased tendency to identify with a particular region of the province.

Alliances have already been formed in accordance with geographic areas. These include an association of mayors on the northwest side and a "senate" representing the Chipewyan bands in the Athabasca and Wollaston Lake areas.

RECOMMENDATIONS

6.1 Northern Saskatchewan should be divided into three distinct HEALTH SERVICES DIVISIONS for the purpose of organizing health care services and managing their delivery.

(a) The health care divisions may be defined as follows:

(i) Churchill River West Division, which would include La Loche, Buffalo Narrows, Ile-à-la-Crosse, Beauval and Pinehouse Lake.

(ii) Athabasca Basin-Wollaston Lake Division, which would include Uranium City, Fond-du-Lac, Stony Rapids, Black Lake and Wollaston Lake.

(iii) La Ronge Division which would include La Ronge, Southend, Sandy Bay, Pelican Narrows, Creighton and Cumberland House.

Governing Structure for the Divisions

A number of factors suggest this may be an opportune time to consider new approaches for the management of health care in the North. These factors include:

A readiness and, indeed, a desire on the part of northern residents to assume responsibility for the management of health services in their communities. Improvements in health care are contingent upon the development of a sense of ownership for the system by northern residents.

A recognition by senior federal, provincial and local government officials of the need for change in the management of health care in the North and an openness to developing new approaches.

The availability of articulate new leaders and respected native elders in northern communities who can facilitate positive change.

Dedicated health professionals with a sincere desire for change and improvement in the availability and delivery of services to northern communities.

RECOMMENDATIONS

6.2 An authority known as the HEALTH SERVICES DIVISION COUNCIL should be established in each northern division to administer health care services which fall under its mandate as designated by the provincial government.

(a) The council should consist of representatives appointed by local elected municipal authorities and Indian bands in the area. Senior officials from the Northern Health Services Branch (Department of Health) and one senior official of the Medical Services Branch (Health and Welfare Canada) should serve as ex-officio members.

(b) Councillors should be appointed for three-year terms, eligible for reappointment for a second term, with a chairperson selected from among the council membership for a one-year term.

(c) Standing committees, chaired by councillors and reporting directly to the council, should be appointed to monitor the categories of health service delivery: acute care services, long-term care services, mental health services, community-based services (public health and home care), alcohol and drug abuse services, and management and finance.

Mandate of the Health Services Division Councils

Residents of northern communities have expressed their desire to develop an ownership for health care services in Northern Saskatchewan. The current situation suggests the time has come for northerners to say, "This is our health care system".

The involvement of local residents in decision-making has proven successful in adapting programs in other fields, such as elementary and secondary education and some post-secondary programs, to meet the unique circumstances of Northern Saskatchewan.

In the health care field, the Catholic Health Council has established local boards at Ile-à-la-Crosse and La Loche and has delegated increasing responsibility for the management of the hospitals in those communities with considerable success.

RECOMMENDATIONS

6.3 The northern division councils should have authority and responsibility for all aspects of health service, including program planning, evaluation, budget management, and delivery of acute care, ambulance services, long-term care, community-based services, home care, mental health, and alcohol and drug abuse treatment.

(a) Division councils should be accountable to the municipal authorities and Indian bands they represent for the comprehensiveness, availability and quality of health services, and to the Department of Health for the effective and appropriate use of financial resources.

(b) Division councils should employ the management and professional staff necessary to administer and deliver programs and services.

(c) Division councils should be directly responsible for institutional services and should either own the facilities or contract their services from private owners such as the Catholic Health Council.

Role of Northern Health Sevices Branch

The role of the Northern Health Services Branch of the Department of Health has to be re-examined and re-defined. The success of the new management structure for northern health will depend considerably on the vision, leadership and support of the Branch.

The Northern Health Services Branch has a mix of health care managers and professionals with a wide variety of experience and knowledge. Many have served the North for years and have acquired an understanding of and sensitivity to northern needs.

Staff of the Branch recognize that dramatic change is necessary in the North, and has expressed its openness to new approaches.

Perhaps most importantly, the Branch has gained an acceptance and respect from northern communities.

These factors suggest the Northern Health Services Branch is in a position to facilitate the reorganization of health services in the North and to provide important management and professional support to the division councils.

Initially, the Branch can provide an array of services, support and leadership to assist division councils as described in the following recommendations. However, it is expected that after some time its role will need to be examined and the partnerships in the delivery of northern health services re-defined.

RECOMMENDATIONS

6.4 The Northern Health Services Branch should continue to function as a separate branch of the Department of Health, responsible for funding and monitoring the standards, comprehensiveness, quality and accessibility of all health services provided by the northern divisions.

(a) The headquarters for the Branch should be in La Ronge.

(b) The Branch should ensure funds made available to the councils provide the basic core services required and reflect government priorities and policies.

6.5 **All functions of the Department of Health for acute care, ambulance services, long-term care, mental health, and community-based services (including home care and public health) in the North - which are currently managed by several branches - should be delegated to the Northern Health Services Branch.**

6.6 **The Northern Health Services Branch should work closely with the division councils and provide consulting and support services to them.**

(a) The Branch's executive director and medical health officer should serve as ex-officio members on the councils.

(b) The Branch should give management support to the divisions by providing administrative backup as required and assistance in the development of operational and management systems training for council members and senior management.

6.7 **The Northern Health Services Branch should have a special responsibility, in partnership with the northern division councils, for recruiting and training professional health care staff.**

(a) Community-based professional staff should be recruited and employed by the Branch, and contracted to the division councils.

(b) The Branch should assist division councils in recruiting professional staff for facilities.

(c) The Branch should provide support and direction to professional staff within the divisions to ensure up-to-date and high-quality health care services.

(d) The Branch and division councils should have joint responsibility for the orientation of new staff and for in-service training, professional development and regular staff conferences.

6.8 **The Northern Health Services Branch should create a financial management unit within its organization to assist northern division councils in all matters related to financial management.**

(a) The responsibilities of such a unit should include budget planning and forecasting, expenditure monitoring and control, auditing and the development of financial systems.

Health Care Facilities

Health care facilities in the North today include hospitals in La Ronge, Uranium City, Ile-à-la-Crosse and La Loche, an inpatient alcohol and drug treatment centre in Ile-à-la-Crosse, an outpatient alcohol and drug treatment centre in La Ronge, and nursing stations in many northern communities.

The need for major efforts to improve and expand institutional and related services - acute care, long-term care, alcohol and drug abuse treatment and mental health - is suggested by such facts as these:

- The hospitals on the west side badly need upgrading; studies have been done in a search for solutions to the shortcomings in institutional care.

- The Uranium City Hospital operates in a community which is no longer viable, and the practicality of continuing to maintain it is questionable.

- A new hospital is being planned for La Ronge.

- Northerners recognize the quality and comprehensiveness of health care services in the North are considerably poorer than in the south, and they justifiably request major improvements.

- There is increasing demand for long-term care beds, and the recommendation for such beds in conjunction with the new La Ronge hospital shows a recognition of this need.

Decisions will be required soon about how to deal with the inadequacies of existing facilities and services. It is timely, therefore, to consider whether changes to the system are required.

In reality, the issue extends beyond concerns about the physical plant to the most appropriate and effective means of ensuring that all northern residents have reasonable access to a wide range of health services. Not all communities can have hospitals, supportive care centres and alcohol treatment centres, but it is important that all have reasonable access to such services and that a strong network links them to central facilities.

RECOMMENDATIONS

6.9 A classification system of northern health care facilities should be established in order to provide a complete range of quality services comparable to those available in southern facilities.

(a) A division hospital should be located in each northern division, providing a wide range of health care services.

(b) Family health care centres, regularly visited by an array of health care professionals, should be situated in several northern communities.

(c) Satellite outreach clinics should be established in small communities, providing basic health care treatment and public health services.

6.10 The facility designated as the DIVISION HOSPITAL in each of the three divisions should be a multipurpose facility ranging in size from 15 to 30 acute care beds (depending on the population served) providing primary and secondary care, as well as other services which might include long-term care, rehabilitation, geriatric care, mental health, alcohol and drug abuse, outpatient and ambulance services.

(a) Division hospitals should be established in each division as follows:

La Ronge Division - La Ronge (acute care, long-term care, mental health, alcohol and drug abuse treatment)

Churchill River West Division - Buffalo Narrows (acute care)

Athabasca Basin-Wollaston Lake Division - Stony Rapids (acute care, long-term care)

(b) Criteria for determining the services, technology and equipment to be available at each division hospital must recognize the unique needs and circumstances of the North, and may result in facilities exceeding those found in communities of similar size in southern Saskatchewan.

(c) Family health care centres and satellite outreach clinics should serve as extensions of the division hospital in their divisions. They should direct patients to the division hospital for more specialized diagnosis and treatment.

(d) Each division hospital should operate a health information telephone service which functions as a crisis hotline and health services information centre.

(e) A sophisticated medical communications system should be developed to allow each division hospital to consult with other facilities in the division and with major facilities outside the North.

6.11 FAMILY HEALTH CARE CENTRES should be established in smaller northern communities in each division, to provide basic health care services, primary care and community-based services on a regular basis.

(a) Division councils should determine the locations of the family health care centres on the basis of existing nursing stations, community need and geographic location.

(b) Each family health care centre should be staffed permanently by no less than three primary care nurses. These nurses and the physicians within the division should function interdependently.

(c) The professional teams visiting the centres should include a wide range of medical and health professionals such as general practitioners, obstetricians, physical and occupational therapists, nutritionists, psychologists, mental health nurses, audiologists, speech and language pathologists and chiropodists.

6.12 To complement the services provided at the division hospital, the facilities at Ile-à-la-Crosse and La Loche should be designated as comprehensive family health care centres and should offer primary inpatient acute care, as well as expanded alcohol and drug abuse treatment and rehabilitation, long-term care and mental health services.

(a) The centre at Ile-à-la-Crosse should include a major alcohol and drug abuse treatment and rehabilitation program for the division, as well as beds designated for primary acute care, long-term care, and mental health, to serve Ile-à-la-Crosse and neighboring communities.

(b) The centre at La Loche should provide primary acute care, alcohol and drug abuse treatment, mental health, and long-term care inpatient beds, primarily directed at fulfilling the needs of its surrounding community.

6.13 All major renovations or new construction of division hospitals and family health care centres in the North should include training facilities for staff and students.

6.14 SATELLITE OUTREACH CLINICS should be established in smaller northern communities where no other formal health services exist, to provide public health, health promotion, basic treatment and emergency services.

(a) The clinics should be staffed by full-time community health workers and assistants under the supervision of a primary care nurse at the nearest family health care centre.

(b) Professional services should be provided through regularly scheduled visits by health professionals, as determined by the division councils.

6.15 Each northern division council should establish a network of funded personal care homes in communities having family health care centres to accommodate Level III and IV residents from surrounding communities.

(a) Each personal care home should accommodate four to five residents, and a resident charge equal to that established in supportive care centres should apply.

(b) The personal care homes should be staffed by resident managers, with medical and health care support provided on an outreach basis from the family health care centre.

Community-Based Services

As already noted, the health problems of northerners far exceed those of residents living in the southern half of the province.

The overall rate of preventable communicable diseases is 5.4 times the provincial rate. Suicides are 21% higher in the North than provincial rates, and the suicide rate for the 15-to-24 age group is 90% higher than the provincial average. The pregnancy rate for girls 15 to 19 is 140 per 1,000 compared to the provincial rate of 46 per 1,000; for girls below 15, the rate is six per 1,000 in the North and virtually zero in southern Saskatchewan. In 1986, the life expectancy of northern men was only 68 years compared to 73.3 for men generally in the province; for women in the North, it was 76.5, and women generally it was 80 (Vital Statistics by Health Region, 1986).

A number of factors contribute to the high incidence of illness, disease and premature death.

- Incomes are low, and unemployment and the cost of living are high.
- Education levels are low, with approximately 50% of the population completing Grade 8 or less, and only 2.6% graduating from high school.
- The standard of housing is often inadequate, and many incidences of overcrowding exist.
- Water and sewage systems are not available in many homes and communities.
- La Ronge is the only northern community with fluoridated drinking water.
- The incidence of alcohol abuse is high, with correspondingly high incidences of spousal and child abuse and neglect.

Some of these situations are outside the control of the health system; however, considerable progress can be made in reducing the health problems in the North if health care providers and communities work together to improve accessibility to basic services and educate residents about healthy lifestyle practices.

A strong community-based program with active public involvement is an important key to improving the health status of northerners. While the challenge is significant, the opportunity has never been better. Community leaders in the North recognize the need and have expressed their desire to become involved in health care at the local level. Furthermore, health care providers and administrators are aware of the importance of community-based services and the need to structure a strong community-based health package.

RECOMMENDATIONS

6.16 The many components of community-based services should be drawn together into a total package within each northern division, and a completely multi-disciplinary team approach taken in the provision of such services.

(a) The package should include mental health counselling and support services, public health nursing for children and adults, public health inspection, alcohol and drug abuse counselling and support services, home care/supportive living services, rehabilitation, speech and language pathology, nutrition, dental care and chiropody.

(b) The division community health services team should include public health nurses, public health inspectors, mental health nurses, community health workers, community health assistants, physical and occupational therapists, nutritionists and speech and language pathologists.

6.17 Each northern division council should establish a special subcommittee to assist in the management of community-based programs, with representatives from the council and senior staff of the Northern Health Services Branch.

(a) The subcommittee should work closely with Northern Health Services Branch personnel on recruitment, employee issues, budget allocations and program planning.

6.18 In order to provide more complete and expanded services, the staff resources allocated to community-based services in the North should be significantly increased.

(a) On the basis of the present population and health conditions, the following allocation of staff for provincially-funded programs in the North would appear appropriate:

public health and primary care nurses - 40
mental health workers - 8
community health workers/assistants - 30
public health inspectors - 3
physical and occupational therapists - 6
speech and language pathologists - 3
nutritionists - 3

6.19 To ensure adequate chiropody services to the North, a chiropody team should be established jointly by the three northern division councils.

(a) The team should be based in La Ronge and administrative responsibility for it assigned to the La Ronge Division Council.

(b) The team should provide services on a regular basis to all communities in the North.

6.20 The role of the community health worker should be significantly expanded in the provision of community-based services in the North.

(a) The community health worker's roles should be that of interpreter, liaison, educator and facilitator, particularly in the following areas:

- provision and co-ordination of home care services
- supervision of satellite clinics
- co-ordination of first responder teams

(b) A new position of **community health assistant** should be established to assist and support the community health worker.

6.21 To effectively integrate alcohol and drug abuse treatment services into the community-based package, a northern arm of the restructured Saskatchewan Alcohol and Drug Abuse Foundation should be established.

(a) The northern Saskatchewan Alcohol and Drug Abuse Foundation (SADAF) should be made up of the three division council chairpersons, the Executive Director of Northern Health Services Branch, and a senior official of the Medical Services Branch, Health and Welfare Canada.

(b) The northern SADAF should be responsible for the overall direction and co-ordination of alcohol and drug abuse services in the North.

(c) As with other community-based services, staff employed for the delivery of alcohol and drug abuse services should be recruited by SADAF and contracted to the individual division councils.

6.22 A health education and promotion program specifically directed to northern residents should be jointly developed by the Northern Health Services Branch and the division councils.

(a) The Northern Health Services Branch should be responsible for the initiation and direction of the program, and the division councils for its administration and delivery at the community level.

6.23 A family counselling program to address the problems of teen pregnancy, family violence and sexually-transmitted diseases in the North should be jointly developed by Northern Health Services Branch and the division councils and administered by the councils.

6.24 Northern community organizations and volunteers should be encouraged by community-based administrators and staff to become involved in developing and implementing health projects and services at the community level.

Medical Transportation Services

There is no northern ambulance system and available emergency and other medical transportation services are unco-ordinated, fragmented and costly.

Many factors indicate the need for and appropriateness of a medical transportation system for the North:

Communities are widely dispersed and distances to medical and treatment facilities are significant.

A road system exists on the west side, which could accommodate a road ambulance service. Previous studies have suggested the suitability of a road ambulance for this area.

A road ambulance service already exists in the La Ronge area.

The isolation of communities and lack of highway systems create a dependency on air travel for medical reasons. Due to the distances and frequent unavailability of the provincial air ambulance plane in Saskatoon, this service is not a practical option for northerners.

Although unco-ordinated and basically unmonitored, private aircraft owners, taxi operators and others have demonstrated their effectiveness in providing medivac services and could complement medical transportation.

RECOMMENDATIONS

6.25 A medical transportation system should be developed in Northern Saskatchewan which ensures a wide range of quality and cost-effective non-emergency and emergency medical transportation services within each division and throughout the North.

(a) Division councils should be responsible for the provision of all medical transportation services, except air ambulance, within their respective divisions.

(b) There should be four categories of medical transportation:

(i) Non-emergency services which transport residents from their communities and homes to health care facilities, or between facilities on a non-emergency basis, and which do not require a specially-equipped vehicle or a qualified health professional in attendance.
(ii) Non-emergency and emergency ground ambulance services which require the attendance of a qualified health professional and/or special equipment in the transfer of patients.
(iii) Medivac services which utilize a variety of modes of transportation to facilitate emergency evacuations and transportation when a road or air ambulance is not available or practical.
(iv) Medical support transportation which utilizes the regular vehicles used for non-emergency medical transportation to transport such items as medical supplies and test specimens and results.

(c) Each division council should establish a central dispatch service at its division hospital.

(d) First responder teams consisting of community volunteers with a community health worker as team facilitator should be formed by each division council throughout its outlying communities.

6.26 Each northern division council should designate a medical transportation co-ordinator to approve and co-ordinate non-emergency medical transportation services, monitor and assess the appropriateness of emergency services initiated and provided, and co-ordinate and administer medivac services for the division.

6.27 A NORTHERN MEDICAL TRANSPORTATION AUTHORITY with headquarters in La Ronge should be established as a chapter of the Saskatchewan Medical Transportation Authority to ensure quality medical transportation services are available and accessible in all northern regions.

(a) Membership should consist of representatives of the northern division councils, the Northern Health Services Branch (Department of Health) and the Medical Services Branch (Health and Welfare Canada).

(b) The Authority should be chaired by a division council representative who will also serve as the northern representative on the Saskatchewan Medical Transportation Authority.

(c) Specific responsibilities of the Authority should include:

  (i) The establishment and monitoring of ambulance service standards to ensure they are in accordance with provincially-established operating standards.
  (ii) The ownership and management of the northern air ambulance program.
  (iii) The development of "first responder" training programs for implementation by division councils.

6.28 Given its unique needs and geography, an air ambulance service should be established exclusively for the North and managed by the Northern Medical Transportation Authority.

(a) The Northern Medical Transportation Authority should arrange for the purchase, lease or rental of a suitably equipped and staffed aircraft to be located in La Ronge.

(b) Air ambulance services should be co-ordinated and dispatched through a central dispatch at the La Ronge Division Hospital.

(c) There should be firm protocols for the use of air ambulance services relative to medivac and ground medical transportation services.

6.29 A ground ambulance system which provides high-quality, cost-effective services and is responsive to the particular needs of individual northern communities should be developed by the La Ronge and Churchill River West divisions.

(a) The La Ronge Division should operate two ambulances located at La Ronge, and the Churchill River West Division should operate four ambulances centred in La Loche, Ile-à-la-Crosse, Buffalo Narrows and Beauval.

(b) Road ambulances should be staffed by qualified emergency medical technicians (EMTs and/or EMT-As) who will also assist in the home-base division hospital or family health care centre, whenever possible. Emergency medical personnel should be available to accompany air ambulance and medivac trips.

6.30 Each division council should provide non-emergency medical transportation services to northern residents needing to travel within or outside their communities for medical purposes, in situations when a specially-equipped vehicle and/or a qualified health professional is not required.

(a) Division councils should purchase, lease or rent vehicles such as vans, or contract the services of local transportation companies, to transport residents.

(b) All trips through this program should be initiated through and authorized by the division medical transportation co-ordinator.

(c) Residents utilizing the service should be charged a basic fee, determined on the basis of economy fares charged by commercial aircraft companies or the Saskatchewan Transportation Company, depending on whether travel is by road or air.

(d) The Department of Social Services and Health and Welfare Canada should be responsible for reimbursing the division councils for transportation costs incurred by social assistance clients and status Indians, respectively.

(e) The basic transportation services provided by this program should also be used to transport medical supplies, test specimens and results, etc. when feasible.

6.31 Quality medivac services should be a component of the comprehensive medical transportation system in the North, and complement air and road ambulance services.

(a) Division councils should be responsible for the provision and management of medivac services within their respective divisions.

(b) Division councils should enter into contracts with first-call medivac providers specifying standards, arrangements and payment rates.

6.32 In order to achieve consistency and equity in user charges, a standard pick-up and mileage fee should be established for all Saskatchewan residents using northern ground and air ambulance and medivac services, with a capping of charges regardless of distance, mode of transportation or patient age.

(a) The Department of Social Services and Health and Welfare Canada should be responsible for the payment of user charges on behalf of their respective clients.

Medical Services

Physicians currently provide primary medical services in the North through two avenues:

- On a fee-for-service basis through private practice.
- On a salaried basis through a contractual arrangement with the College of Medicine, University of Saskatchewan.

In co-operation with the Northern Health Services Branch, the College of Medicine developed a process by which it enters into contracts with physicians to provide services to communities which are unable to recruit them. At present, Ile-à-la-Crosse and surrounding communities receive their medical services through this arrangement.

The College of Medicine also helps provide specialist services to Northern Saskatchewan. It finds specialists interested in providing visiting services to the North and arranges for their services. These specialist services are provided on either a fee-for-service basis or a contractual arrangement with the College.

The Commission was impressed with the medical services that are being provided under contract with the College of Medicine. This arrangement has contributed to a continuity and stability of medical services for a number of communities that far exceeds any previous arrangements.

It is expected that for the near future, at least, many northern communities will continue to have difficulty recruiting and retaining medical personnel. Many physicians lack experience with, and understanding of, the health and social problems which exist in the North. In addition, like other health care workers from outside the North, they lack the cultural and language backgrounds. These factors, combined with the physical and professional isolation of the North, make the recruitment and retention of physicians there even more difficult than in rural Saskatchewan.

In the long term, one solution is training and recruiting northerners to provide medical services, and efforts must be made to work towards this goal.

However, steps need to be taken in the interim to ensure adequate and quality medical coverage for northern communities.

RECOMMENDATIONS

6.33 The main base for medical practice in each northern division should be the community in which the division hospital is located, and that practice should consist of a group of at least three physicians.

(a) Medical services to small communities should be provided through regular visits.

(b) The role of the primary care nurse as the initial contact for primary care services should be expanded in the smaller communities, with the necessary medical backup being provided by the physicians in the division centres.

6.34 Northern division councils should have the primary responsibility for ensuring that adequate physician services are available within their divisions, through contractual arrangements with the College of Medicine, or through incentives for the establishment of a fee-for-service group practice, or a council-operated capitation practice such as a community clinic.

6.35 The College of Medicine, through the Northern Medical Services Unit, should provide a central recruitment support service for division councils in order to locate general practitioners and selected specialists who may be interested in practising medicine in northern communities.

6.36 The College of Medicine should continue and expand its services to increase itinerant specialist services to northern division hospitals and outlying communities, including co-ordination of detailed travel and administrative arrangements and orientation to northern cultures and circumstances.

6.37 Division councils, the College of Medicine and the Northern Health Services Branch should together be responsible for developing and maintaining an environment which provides medical practitioners with necessary professional support systems and benefits.

(a) Situations and initiatives contributing towards an attractive practice environment should include:

- Adequately staffed and equipped division hospitals.

- First-class emergency response and ambulance systems.
- Access to itinerant specialist services.
- Sophisticated communication and diagnostic equipment which provides for transmission between the division hospitals and their satellites, and with major southern facilities.
- Development of medical research programs and activities in the North.
- Provisions for vacation and educational leave benefits.
- Adequate housing.

Health Professional Training for Northerners

As noted in the foreword, recruiting and retaining health professionals is a serious problem in the North. This situation is compounded by the fact that few northerners fill professional and paraprofessional positions; in many disciplines, there are none.

A number of training programs exist for status and non-status Indians, as well as for other northern residents. However, these programs require co-ordination, are administered by a variety of agencies, and are often provided outside the North.

One health care position which has attracted northern residents is the community health worker (known as the community health representative in federal programs). The community health workers are recruited from the northern communities in which they work, and they basically provide community liaison and health education services.

Community health workers have demonstrated the ability to communicate with and influence northern residents. Northerners and health care providers have come to respect these workers and request their services.

The success of the community health workers is evidence of the effectiveness of northerners occupying health care positions. It also indicates the capacity and interest within communities to become involved in health care delivery.

Northern communities can provide an important resource for the health care system. The opportunity exists to capitalize on this resource, and by so doing, to fulfill three important needs:

- Create employment opportunities, and incentives for young people to continue their education;
- Involve northerners in health care delivery;

- And, most importantly for the health care system, train and recruit quality health professionals.

The isolation and the culture of the North pose some problems in developing training opportunities for northerners; however, efforts must be made to ensure training programs are co-ordinated, available and accessible to northern residents.

RECOMMENDATIONS

6.38 The Department of Education, Northern Health Services Branch and northern division councils should jointly develop an aggressive program to make northern high school students aware of the need for native health care professionals in the new system and of the opportunities available to them.

(a) The program may include such initiatives as career days, presentations by health care professionals, and student visits to health care facilities and programs within a division.

6.39 The proposed Health Manpower Branch of the Department of Health should develop a special focus on the manpower needs of the North, with the primary objective of encouraging northerners to train in the health care field.

(a) A special **northern manpower advisory committee** should be appointed by the Deputy Minister of Health to advise the Branch. Representation on this working group should include the Northern Health Services Branch; the Medical Services Branch, Health and Welfare Canada; northern division councils; the Department of Education; the University of Saskatchewan; and the Saskatchewan Institute of Applied Science and Technology. The Health Manpower Branch should serve the secretariat function.

(b) The Branch and the northern manpower advisory committee should jointly assess the northern manpower needs and the training programs that currently exist for northern residents, and develop a plan of action which will result in education programs that are co-ordinated, available and accessible to northern residents.

(c) Health career training programs developed through the Health Manpower Branch and its northern manpower advisory committee should be sensitive to the cultures and languages of northern students and should attempt to provide for classroom delivery in northern communities for at least the introductory levels of university and technical institute programs, such as nursing, physical therapy and nutrition.

(d) The Health Manpower Branch and the northern manpower advisory committee should ensure education training programs are available through northern high schools and other educational institutions such as community colleges, to provide students and adults with the necessary classes and upgrading to meet prerequisite requirements for health professional training programs.

6.40 The Department of Health, through the Northern Health Services Branch, should provide an incentives program to encourage northern residents to pursue health careers, with financial assistance toward the cost of training, books, travel and accommodation being a major element of the program.

(a) A return-in-service commitment to the North should be stipulated as a condition of any financial assistance.

6.41 Federal and provincial officials should work together to expand and revise the federal community health representative training program into a jointly-sponsored program which trains northern residents as community health workers and community health assistants.

(a) A one-year diploma program for community health workers should be headquartered in La Ronge.

(b) The first three months of the program should provide basic orientation to community health and should be offered in local communities. Successful completion of this portion should provide the necessary qualification for a community health worker assistant.

(c) The remaining nine months of the program should involve six months of classroom instruction followed by a three-month practicum in the student's community. Successful completion of the 12-month program should earn the community health worker qualification.

(d) A primary care nurse should supervise the course practicum.

(e) As their future employers, division councils should nominate the candidates for this program.

6.42 Division councils, in co-operation with the Northern Health Services Branch, should develop summer employment opportunities within their programs and facilities to give students interested in health careers opportunities for first-hand experience.

6.43 Institutions such as the University of Saskatchewan and the Saskatchewan Institute of Applied Science and Technology, which train health professionals, and the northern division councils should jointly develop a program which promotes and encourages health care student practicums in northern communities and institutions.

Staff Recruitment and Retention

Under the proposed health care structure for the North, the responsibility for recruiting staff for provincially-funded programs would be shared by the division councils and the Northern Health Services Branch.

The Branch has a sound understanding of the problems associated with recruitment in the North, and is in a position to provide strong leadership and support in developing hiring and employment practices which could facilitate recruitment and retention of staff. The councils would have a thorough knowledge of the conditions in their communities concerning such staff needs as housing.

As a team, the councils and the Branch can work to improve the staffing situation in the North. Employment benefits and conditions should be competitive with other employing agencies in Northern Saskatchewan and incentives should be provided to encourage employees to remain in the North.

RECOMMENDATIONS

6.44 The Department of Health and the Public Service Commission should adopt human resources management policies which provide the Northern Health Services Branch with the authority and flexibility to staff its own positions and enable it to support the division councils in their recruitment efforts.

(a) A human resources function should be established within the Northern Health Services Branch in La Ronge.

(b) The Northern Health Services Branch should develop a pro-active recruitment strategy which includes such activities as visits to in- and out-of-province campuses, and professional conferences.

6.45 In order to recruit and retain health care professionals and support staff in northern communities and institutions, special compensation packages should be developed by the northern division councils and the Northern Health Services Branch.

(a) Salary levels should be increased to equal or exceed what is paid by other health care employers in the North.

(b) Salary levels paid to northern employees should reflect the northern cost of living differential.

(c) Employees should receive a bonus upon completion of each year of service.

(d) A signing bonus with a return-in-service commitment should be paid in two instalments to all new employees during their first year of service.

6.46 Northern division councils should be responsible for all matters related to staff housing and for ensuring adequate housing is available for staff when required.

(a) Furnished rental units should be available to all northern staff, except those in La Ronge and Creighton.

(b) Housing and maintenance standards should be established and improved from current levels.

(c) Whenever possible, housing should consist of multiplex buildings rather than single dwellings.

6.47 Employment policies and practices should take into account such factors as isolation and distances, and include provisions for leave with pay to accommodate special medical, rest and service needs.

6.48 Initiatives to enhance professional support for northern staff should be developed jointly by the Northern Health Services Branch and the northern division councils and should include a minimum amount of paid educational leave, regular professional conferences for northern staff, and communications technology linking professionals with each other and with other professional jurisdictions.

6.49 An orientation program that combines seminars, community visits and interviews with professionals practising in the North should be developed by the Northern Health Services Branch and the division councils to ensure all new staff are familiar with and sensitive to the cultures, needs and circumstances of the North.

Special Needs Programs

It is evident the special health needs of the North require the introduction of programs and services that exceed those available in the south.

The school-based dental program in the North has been effective in controlling dental cavities and encouraging better dental hygiene among school-age children.

However, the dental health needs of adults have remained unmet and their dental health is poor.

In many communities, people can't afford healthy foods even if they are available. Health promotion efforts to encourage healthier eating habits are unlikely to succeed if northern families can't afford to buy healthy foods.

RECOMMENDATIONS

6.50 To improve the dental health of the general northern population, the Children's Dental Program delivered through the Northern Health Services Branch - which provides basic dental services to children aged five to 13 - should be extended to make these same basic services available to northern residents of all ages.

(a) The services should be delivered by teams of dental therapists and dental assistants, under the distance supervision and involvement of a dentist. A complement of six dental therapists, six dental assistants, two dentists and one equipment technician is expected to be required.

(b) Dental services for school-age children should continue to be school-based; services for pre-school children and adults should be provided at family health care centres.

(c) Legislation and regulations should be amended to allow dental therapists and assistants to deliver services in the absence of an on-site dentist.

(d) Arrangements should be worked out with the federal government to provide, through its existing program, training for dental therapists who would be employed by the Northern Health Services Branch to provide services to children and adults.

6.51 Selective government subsidies should be developed to make basic, healthy foods accessible and affordable to all residents of Northern Saskatchewan.

(a) Policies should clearly identify the foods to be subsidized and should exclude foods and related products with little or no nutritional value.

(b) The program should be based on the general principle that residents of Northern Saskatchewan should not be required to pay more for selected foods than southern residents.

(c) The subsidies should be only for foods bought for personal consumption and should exclude foods bought for profit by commercial establishments.

Co-ordination among Provincial Agencies

The potential impact of a decision by one agency on the plans and priorities of another is far greater in northern communities than elsewhere in Saskatchewan. In a particular way, policy decisions about housing, food subsidies, economic development and recreation impact on health programming for northern residents.

A mechanism is required in the North which involves all the social policy agencies and recognizes the interdependencies among them.

RECOMMENDATIONS

6.52 A NORTHERN SOCIAL POLICY SECRETARIAT with headquarters in La Ronge should be formed with representation from all government services which affect the health and well-being of northern residents.

(a) The secretariat's mandate, clearly defined in legislation, should be to examine all major proposals and plans of the departments represented, and to make recommendations to the respective deputy ministers based on their effects on northern people, their communities and their environment.

(b) The secretariat's members should be the executive directors responsible for northern health services in the fields of social services, education, housing, environment, industry, economic and recreational development and health.

(c) The secretariat should second a small staff from the departments represented to co-ordinate information, analyse proposals and communicate about specific projects.

(d) The secretariat should report annually to the Deputy Minister to the Premier, the division councils and the deputy ministers of each department represented.

Federal/Provincial Roles

At present, the approximately 30,000 people living in Northern Saskatchewan are served by two health care systems, one administered by the Medical Services Branch of Health and Welfare Canada and the other by the Northern Health Services Branch of the provincial Department of Health.

The federal government's jurisdiction applies to status Indians, while the provincial government is responsible for services to all other residents.

The need for two systems is questionable. Serious consideration must be given to the integration of these health services.

Both federal and provincial authorities recognize the inconsistencies, inefficiencies and even gaps in service created by the existence of two systems, and both levels of government have expressed a willingness to work toward changing them. Furthermore, they have demonstrated the ability to work co-operatively.

An atmosphere of change has already begun to develop in the North, with federal initiatives to transfer responsibility for health services to individual Indian bands.

Treaty agreements provide certain benefits and services to status Indians, and these must be honored. On the other hand, the potential for greatly improved services to both status and non-status residents as a result of combining the two systems must be considered.

A single strong health system for the North is possible, if the commitment exists and meaningful consultations occur among the federal and provincial governments and the tribal councils.

RECOMMENDATIONS

6.53 In order to achieve a comprehensive health care system for all residents of the North, federal and provincial health services should be combined and responsibility for their delivery assigned to the division councils on behalf of all residents of their divisions.

(a) A panel of provincial and federal officials should be established to examine and identify the services and programs that can be amalgamated.

(b) In order to achieve the objective of a single system, a planning and implementation committee should be established, consisting of one status and one non-status resident from each division, plus representatives from the Northern Health Services Branch and the Medical Services Branch of Health and Welfare Canada.

(c) Federal and provincial co-operation and co-ordination should be pursued in:

(i) funding the development, construction and operation of division facilities.

(ii) delivery of community-based programs and ambulance services.
(iii) establishment of education programs for health care professionals and paraprofessionals.

Exhibit A:
Proposed Health Divisions
for Northern Saskatchewan

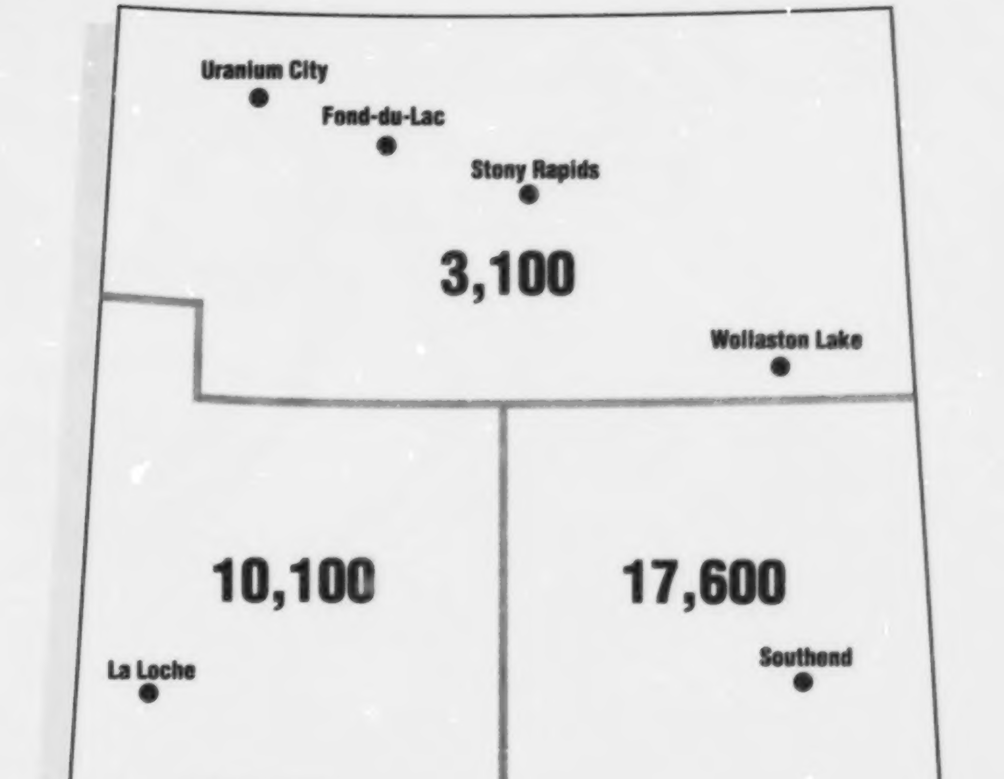

Uranium City
Fond-du-Lac
Stony Rapids
3,100
Wollaston Lake
10,100
17,600
La Loche
Southend
Buffalo Narrows
Sandy Bay
Ile-à-la-Crosse
La Ronge
Beauval
Creighton
Meadow Lake
Prince Albert
Nipawin

Exhibit B:
Illustrative Representation on the Northern Division Councils

1. CHURCHILL RIVER WEST DIVISION

	Location/Agency	**Number of Representatives**
	La Loche	2 (one from the Big C Band and one from the community)
	Buffalo Narrows	1
	Ile-à-la-Crosse	1
	Beauval	1
	Cole Bay - Jans Bay	1
	Michel - St. George's Hill	1
	Pinehouse	1
	Turnor Lake	1
	Local Indian Bands	2
*	Northern Health Services Branch	2 (ex-officio)
**	Medical Services Branch	1 (ex-officio)

2. ATHABASCA BASIN/WOLLASTON LAKE DIVISION

	Location/Agency	**Number of Representatives**
	Wollaston Lake	1
	Uranium City	2
	Stony Rapids	2
	Local Indian Bands	3
*	Northern Health Services Branch	2 (ex-officio)
**	Medical Services Branch	1 (ex-officio)

3. LA RONGE DIVISION

	Location/Agency	**Number of Representatives**
	Southend - Brabant Lake	1
	Sandy Bay	1
	Pelican Narrows	2 (one from the Peter Ballantyne Band and one from the community)
	Creighton/Denare Beach	2
	Stanley Mission	1
	La Ronge	2 (one from the Lac La Ronge Band and one from the community)
	Air Ronge	1
	Weyakwin	1
*	Northern Health Services Branch	2 (ex-officio)
**	Medical Services Branch	1 (ex-officio)

* Saskatchewan Department of Health
** Health and Welfare Canada

Exhibit C: Population Profile of Northern Saskatchewan from 1978 to 2010

Age	**1978**		**1983**	
0-19 Years	14,599	(53.8%)	14,296	(50.5%)
20-64 Years	11,668	(43.0%)	12,938	(45.7%)
over 65 years	868	(3.2%)	1,076	(3.8%)
TOTAL	27,135	(100.00%)	28,310	(100.00%)

Age	**1989**		**2000**		**2010**	
0-19 Years	14,812	(48.1%)	14,599	(53.8%)	14,296	(50.5%)
20-64 Years	14,751	(47.9%)	11,668	(43.0%)	12,938	(45.7%)
over 65 years	1,232	(4.0%)	868	(3.2%)	1,076	(3.8%)
TOTAL	30,795	(100.00%)	37,375	(100.00%)	42,500	(100.00%)

Sources:

1. Population figures obtained from Saskatchewan Health Insurance Registration: Covered Population for the years 1978, 1983, 1989.
   Northern Saskatchewan Community Directory, Northern Affairs Secretariat, 1987.

2. Projections were based on reports from the Population Projection Section, Demography Division, Statistics Canada:

   1. Population Projections of Registered Indians, 1982 - 1996, February 1985.
   2. Migration Projections of Registered Indians, 1982 - 1986, July 1985.
   3. Fertility Projections of Registered Indians, 1982 - 1996, April 1985.

Exhibit D:
Northern Saskatchewan
Health Problem Indicators

1985 COMMUNICABLE DISEASE RATES (North Times Provincial Average)

Tuberculosis	1500%
Gonorrhea	1410%
Hepatitis A	600%
Measles	420%
Bacterial Meningitis	370%
Amaebiasis	180%
Shigella	130%
Giardiasis	110%
Salmonella	103%

TEN-YEAR DEATH RATES 1974 - 1983 (North Times Provincial Average)

Other Transport (males)	680%
Drownings (female)	650%
Drownings (male)	540%
Other Transport (Female)	460%
Liver Cirrhosis (female)	440%
Homicide (16-24 yrs. old)	390%
Firearms (male)	380%
Cancer of Cervix (female)	290%
Oral Cancer (female)	270%
Lung Cancer (female)	270%
Poisoning (female)	260%
Pancreatic Cancer (female)	250%
Accidental Deaths (male)	230%
Accidental Death (female)	200%
Diabetes Mellitus (female)	200%
Fires (male)	190%
Suicides (15-24 yrs. old)	190%
Diabetes Mellitus (male)	170%
Alcohol/Motor Vehicle (male)	170%
Pneumonia (female)	170%
Motor Vehicle (male)	170%
Motor Vehicle (female)	160%
Alcohol/Motor Vehicle (female)	160%
Lung Cancer (male)	140%
Pneumonia (male)	140%

Source: Northern Health Services Branch, Saskatchewan Department of Health.

COMMENTARIES ON HEALTH-RELATED ISSUES

Commentaries on Health-Related Issues

- *Foreword*
- *Caring and Compassion*
- *Environment*
- *Smart Card*
- *AIDS*
- *Abortion*
- *Midwifery*
- *Medicine Men*
- *Employment Conditions and Benefits*

Foreword

Soon after its appointment in 1988, the Commission issued an invitation to people and groups interested in and concerned about Saskatchewan's health care, to express those interests, concerns and suggestions for change at public meetings or in private briefs.

The response was impressive. The Commission received almost 600 briefs and written submissions from a variety of individuals and organizations. In addition, each Commissioner had discussions with many people from across the province. It was evident to the Commission that everybody it spoke to or received briefs from had thought carefully about their subjects and often felt strongly about them.

Thousands of ideas, concerns and issues were expressed to the Commission and not every one could be addressed in this report without making its recommendations so voluminous as to be almost unreadable. Too, Commissioners were conscious that their mandate and, in some cases, circumstances that are still changing, made it impossible for them to propose specific recommendations on certain issues.

The absence of certain topics from those recommendations should not be construed as an indication the Commission did not find presentations on those subjects worthwhile or helpful. Quite the opposite; it was impressed by many of the groups and the ideas they shared, especially those small volunteer groups fighting to improve the lives and prospects of people - perhaps just a few - who are victims of diseases and disorders that are not widespread, but still harmful and debilitating.

With some other subjects, the Commission considered them, developed certain ideas about them and decided on a special commentary section in its report to share those ideas. The topics involve issues which extend beyond purely health considerations, and in fact, present cultural, social, technological, and even moral questions. However, all the topics, in some manner, touch on the health care system, and it is the Commission's hope its ideas may form the basis for consideration and discussion by those with particular responsibilities in these areas.

Caring and Compassion

Each Commissioner has found his or her time with the Commission one of great learning. The one great truth which was reinforced at each and every public hearing was that good health is a gift beyond price.

Illness can be devastating to the individual and his or her family. Blindness, the inability to walk, a drug addiction or an affliction of the mind rob many citizens of the ability to enjoy life to its fullest and the satisfaction of contributing fully to the well-being of families, friends and community. Good health is an important attribute which our society must continue to foster. Indeed, it could be said the primary purpose of ***all*** government programs should be to encourage the development of a more healthful society.

It must also be said that our knowledge of the origins, causes and courses of many illnesses and diseases is still incomplete. Cures for diseases such as lung cancer, multiple sclerosis or AIDS may be some years in the future. It is therefore important that the focus of many of our health care efforts shift from curing to caring. It is important that the rightful quest to add years to life does not obscure the importance of adding life to years.

The Commission hopes this compassion for the ill and disabled can be channelled into those social and health programs which will do the most good. The mentally ill desperately need opportunities for employment and interaction with the mainstream of society. The head injured need ongoing rehabilitation programs once the immediate post-trauma period of hospitalization is over. The frail elderly living alone crave opportunities for fellowship and social interaction. Youth on drugs need opportunities to develop self-esteem and channel their energies into positive programs for growth and self-improvement.

In many cases, families have been carrying enormous and sometimes frightening loads without properly-directed help that would lessen the strain and stress. Commissioners heard, for example, from families of autistic children, or those who drive six hours to take their children for therapy sessions. Sufferers from multiple sclerosis or cerebral palsy or lupus erythematosus may be few in numbers, but they have real and undeniable needs.

Though its recommendations may not have touched directly on those diseases, the people who suffer from them and the families and groups dedicated to helping them, the Commission hopes its determined push for top-quality, well-staffed community-based programs, its emphasis on health promotion and more caring institutional care, and its concern for non-government organizations may prove valuable to them, even if indirectly.

The Commission accepts that in a truly caring health system, it is not enough just to pay doctors, build hospitals and more long-term care beds, or even to offer topnotch community services. The ill, disabled and unfortunate need opportunities to participate in the mainstream of life rather than be condemned to a life of isolation. A truly caring and compassionate society owes its less fortunate a lot more than just medicare or hospitalization insurance.

Environment

The Commission's report has emphasized the impact of the lifestyles of Saskatchewan people on their health, and has stressed how important it is that people assume responsibility for their own personal health and for the health of others as well, that is, for the community generally. Clearly, if each person eats properly, gets regular exercise and avoids activities that are detrimental to good health, great strides can be made in improving the healthiness of the population. It may be even more important, however, for personal health and the health of our planet, that at least as much attention is devoted to the environment.

Although the impact of environmental pollutants on health remains relatively unmeasured, there is absolutely no doubt of their harmful effects. Equally, there is no doubt that mankind's future existence depends on its ability to protect the environment. Unless major steps are taken now to control pollution, it could be too late to undo the damage and there won't be an environment for future generations.

This is *the* issue of the 1990s. Society is becoming increasingly conscious of environmental concerns, ranging from the food people eat to the water they drink, the air they breathe and the atmosphere to which they are exposed. There have been significant advances in developing the technology and the means to clean up environmental pollutants, and even to store them safely; unfortunately, there is little noteworthy to say about progress in preventing the pollution in the first place.

The environment is shared; the responsibility for protecting it must be shared, too, by each individual, the general public, all levels of government, and private industry. None should wait for leadership from elsewhere; all must be willing to forfeit some immediate benefits for the long-term good of all. Those truths seem to be already accepted by individuals who are eager to recycle and who are taking steps to stop polluting. A similar degree of eagerness, initiative and activity is demanded from corporations and businesses. They must not wait to be pushed by legislation, but must act now to control their polluting ways, to demonstrate a sense of corporate responsibility and citizenship. Before a forest is cut down for the products and profit it will produce, for example, the contribution that forest makes to the protection and balancing of the environment must be considered.

For a long time, here in the fresh air and giant spaces of Saskatchewan, we have felt untouched by the pollution that in some cities makes daily air quality reports a necessity, by the fallout that creates lakes in which fish cannot live, or by the industrial emissions and wastes whose effects on humans may not be discovered for years. However, our security blanket is pretty tattered now, and we know that we, too, must do our share to preserve the environment.

The Commission is aware of a variety of initiatives taken in this province, which attempt separately to monitor, control and do research on environmental concerns. That is all well and good, but what is badly needed is a co-ordinated and unified approach. Such an approach requires strong and assertive leadership on the part of the provincial government.

The Commission calls on the Government of Saskatchewan to assume a strong and positive role in addressing environmental issues, and accordingly, it suggests the establishment of a high profile, independent, provincial agency with a clearly defined and strongly focused mandate. The agency must be given responsibility for monitoring environmental conditions, investigating concerns, recommending environmental policies, undertaking research, and educating the public, government, and industry on environmental issues. It is important the academic and research communities, private industry, agriculture, health care providers and government all be involved in governing the agency.

It is also the job of the provincial government to establish standards, requirements and regulations to protect the environment from harmful industrial practices. It must do so at once, and ensure such standards are adhered to by individuals, industry, and all levels of government and government agencies. It should also develop public policies which ensure all private and government services, programs and products are environmentally safe. Strong, forthright leadership is needed.

While it is happy to see the kind of personal responsibility many people are now taking for the environment, the Commission considers it vital that such efforts continue and increase. All sectors of society must be made to understand the importance of protecting the environment, the factors threatening it, and what can be done to preserve it. In this context, it is important to strike while the iron is hot; people are becoming more and more conscious of the value of recycling, for example, but if municipal and provincial governments fail to provide the depots to collect all kinds of recyclable goods, the eagerness to do something could be lost.

Often it is the young who have led in demands for action to protect and preserve the environment. It is clear that educators are beginning to use their particular opportunity to teach young people about preserving the environment, and the Commission encourages them to continue to do so. It believes, too, that environmental education should form part of our schools' curriculum.

The Commission's mandate was to study health care and recommend a system that would meet the needs of the 1990s and the 21st century. It has done that, but in full awareness that if the environment is working against it, the most wonderful health care can be all in vain. The steps we take in this decade to curtail further pollution of and damage to the environment are going to be critical to our health care, and indeed, our very existence. In this decade of the environment, when it is almost too late to stop the destruction, the Commission challenges Saskatchewan residents to do their part - and, indeed, in the true Saskatchewan tradition, probably more than their part - to make this province, Canada and the world around us healthier places in which to live.

Smart Card

The new plastic Health Services Card has been a success with respect to the automation of the Saskatchewan Prescription Drug Plan. It offers two advantages:

- it identifies the eligibility of beneficiaries and their family members.
- the on-line system allows the deductible policy to be administered when a prescription is purchased.

The card has provided an administrative convenience for pharmacists and a financial benefit to the public, by providing up-to-date information on the deductible.

At present, the card's capability is limited to these functions - but it promises much, much more, and Saskatchewan must understand that promise and develop a plan to use it effectively when it becomes possible to do so.

Technology is being developed which could significantly expand the plastic card's potential and make it a true "smart card". A microchip which would carry a person's complete medical history could be imbedded in the card, and the person would take it along to the doctor, the hospital and the lab, where staff would use a computer terminal to get access to and update provincial health files.

The introduction of "smart card" technology in combination with Saskatchewan's invaluable database has great potential for the health care system. The "smart card" could link all health care agencies, providers, and insurers and thereby facilitate access to personal information databases about a patient's health status. This network could contribute significantly to more effective and efficient health care delivery. For example, it could provide the health care giver with access to detailed medication profiles with information about allergy alerts, and could facilitate the monitoring and control of prescription drug abuse. It could also provide valuable medical histories in emergencies and other situations even when a patient is unconscious. Numerous administrative advantages are also evident in such areas as claims processing.

However, there are problems with the concept which have not yet been solved. The health care industry - with all of its thousands of separate organizations and practitioners - would have to agree to a single uniform approach to recording an individual's medical history. Every practitioner and hospital would have to have the technology to read the card, and to update it after seeing the patient. The necessity for this technology is one of the reasons introducing a "smart card" is estimated to cost $10 to $15 per person per card.

The confidentiality of patient information and the need for informed consent are obviously concerns in the introduction of this technology. Such confidentiality is possible, especially if the card is the property of the patient, but it is expensive. Another concern is finding a way to ensure the information on the card is accurate, since several different people will be updating it.

Acknowledging the problems that make use of a "smart card" difficult today does not mean it cannot be done. Quite the contrary; technology will certainly solve the problems. A great deal of refinement is required, but the "smart card" is going to be a valuable health services tool.

Many provinces are examining the idea of such cards, and it is important there should be mechanisms in place to share the information and ideas that are proposed. Given its experience with the plastic health card and its internationally renowned database, Saskatchewan is in an excellent position to move gradually towards a fully-fledged "smart card", for rapid access to data profiles of individuals' medical histories, to obtain research-related information, and to monitor for possible abuses.

Such developments should occur gradually, in a number of stages over several years.

The first step might be to develop and issue magnetic-stripe "pointer" plastic cards carrying the names and telephone numbers of physicians or facilities with medical information about an individual. At the scene of an accident, for example, emergency medical technicians could phone that number to find out if an unconscious victim is allergic to any antibiotics.

The next step could be the introduction of "smart card" technology in hospitals and supportive care centres to replace paper records.

The final step could be the development of a province-wide integrated health record system.

The Commission is convinced that technology is less of a barrier to the development of new information systems than our collective willingness to make the necessary organizational and legal changes.

It supports the idea of further investigation of the use of "smart card" technology and encourages the government to take concrete steps to ensure the potential of every aspect of this technology is explored, and an implementation strategy developed in the near future.

AIDS

Throughout history there have been killer diseases which frightened and threatened mankind. Bubonic plague was one such disease, which was understandably called The Black Death. Smallpox was another, before modern medicine eliminated it. What set them apart from other feared diseases was their very deadliness and the mystery associated with their appearance.

We know a great deal about the newest killer disease, acquired immune deficiency syndrome (AIDS), though not yet enough. We have seen it spread, first among certain targeted populations and then more generally. We know if we start edging towards the incidence of the disease as it prevails in some other parts of the world, our health system would become overwhelmed.

Up to March 26, there had been 3,604 cases of AIDS in Canada, and 2,169 deaths, and health officials now expect the rate to double every 20 months. In Saskatchewan, there have been 33 cases and 20 deaths; the number of cases doubled in the last 24 months.

Although this country has so far escaped the shocking number of cases first predicted, AIDS is not under control and every indicator suggests it will increase, here as elsewhere. It's hard to determine the rate of increase because strenuous efforts are being made to contain its spread, but it would be wildly optimistic to even hope it is being contained. We have not yet seen the worst of AIDS, and concern about its continuing spread can only be increased by the knowledge that there are several ways of contracting it.

Given this situation, given the present incidence of AIDS and the likelihood it will increase, it is vital for Saskatchewan, like all jurisdictions, to act on two fronts: to cope more effectively with the existing cases and to educate everyone in this province about the disease, how it is contracted and how it can be prevented in this age of increasing sexual freedom and increasing drug use.

Some educational efforts have already been made, led by the Department of Health. More stress is needed, however, on tackling this subject in imaginative, hard-hitting and compelling ways. A society that relies on the media, especially television, as much as ours does must get factual, informative and unforgettable messages about AIDS from those media.

To be most effective, campaigns about AIDS should be specifically tailored to different age groups. It is no use hoping that a campaign aimed at 40-year-olds will also have an impact on teenagers.

It is vital, too, that such campaigns hammer home one crucial fact: it is pointless to try to hide behind the idea that "it won't happen to me". AIDS has been happening to "me" all over the world; it has killed 20 of "me" in this province. In each of the last three years, there have been seven, eight or nine new cases of AIDS in Saskatchewan.

Because this is a large province with a small population and relatively small cities, the AIDS campaign must have a provincial focus. Programs and services for victims must be offered in a setting that serves more than the immediate community. Many AIDS victims are going to congregate in Regina and Saskatoon and therefore the division councils of those cities will have a special responsibility to provide services in their hospitals and in small group homes which could offer palliative care in supportive environments. They must have special provincial funding for this purpose.

Along with continuing education efforts targeted at specific groups, carefully planned and implemented treatment strategies, and facilities that help victims maintain a normal lifestyle for as long as possible and offer them support when a normal lifestyle is no longer possible, Saskatchewan must make sure to remember the need for compassion for those victims. There is no room for accusation and blame. The health system, and all of us, must ensure AIDS victims get the same tender care and compassion as all the other ill.

Abortion

During its hearings, the Commission received a number of presentations about abortion. Not surprisingly, two distinct points of view were presented: one taking a firm stand against abortion and one advocating pro-choice. There were no proposals made between these two extremes that could have resulted in any meeting of minds.

Recognizing the seriousness of the issue, the Commission undertook to give it thorough consideration and analysis. In so doing, it had to be mindful of its mandate, which is to study and make recommendations on a range of health issues which affect the quality, availability, accessibility and cost of health care services in Saskatchewan.

Abortion is funded in Saskatchewan as a medical procedure and the Commission attempted to address this controversial issue purely on health terms. However, in studying the matter, it had to acknowledge the health aspect of abortion is relatively minor compared to the moral, religious and political considerations.

Given this fact, the Commission decided that before it could address the health-related issues around abortion, the other questions had to be decided by society. It is not up to a Commission examining health care to say that abortion is morally acceptable or morally unacceptable.

Because of the nature of the problem and the focus it is receiving in our society today, it becomes obvious the abortion issue must first be considered and addressed by our legislators. It is currently under review and debate by the federal government, in an attempt to reach consensus in the form of legislation.

Midwifery

A number of groups recommended to the Commission that midwifery be recognized as a profession and encouraged across Saskatchewan. Midwives, these groups said, are perceived as being willing and able to spend more time with maternity patients than physicians, and to have time for and interest in counselling, education and moral support of mothers both before and after the birth.

The need for midwives must be considered within the Saskatchewan context. The birth rate in the province is slowly falling, and there are now about 17,350 live births each year. Most babies are delivered in the larger centres.

Comparatively speaking, Saskatchewan has a high rate of teenage pregnancies. At the other end of the spectrum, more and more women are delaying childbearing until careers and other interests have become established, and hence, the fertility rate in the 30-39 year age group is increasing. These situations contribute to increased incidences of high-risk pregnancies.

Some of those who presented briefs to the Commission argued the idea that midwifery has gained some prominence and acceptance because doctors have not done as well as they might have at advising and counselling women, or in giving them the particularly gentle care they need at this time. However, the Commission notes there has been a significant increase in the number of deliveries performed by female physicians, and they are seen by their patients as understanding and compassionate.

The Commission sees a role for the midwife as part of the obstetrical team at the time when a woman gives birth, a person who can stay with her, offering encouragement and support, when doctors and nurses are responding to other demands on their time. It suggests midwives also have a role to play in the periods before and after birth to teach new mothers about their responsibilities and, after the baby is born, how to fulfil those responsibilities.

That being the case, the Commission suggests it would be timely to explore the idea of a program of preparation for midwifery, for there is nothing at present in Canada. It believes the nursing program has many of the elements which are basic to the skills required by midwives and suggests the best possibility for developing a program may be with the nurse training institutions of the three prairie provinces.

It could be appropriate, the Commission believes, for common standards for midwifery to be developed for the three prairie provinces. These standards would determine the components of the training program, and those who successfully met those standards should be licensed by their respective provinces.

Medicine Men

Long before white men reached the shores of North America, the illnesses of its first residents were dealt with by medicine men. Each tribe had a few greatly-esteemed healers whose knowledge of the local plants and herbs that would cure illnesses was as broad as their respect for the spirits that brought such illness.

The cures of these medicine men dealt with the mind and spirit of the sick person as much as with the body. They were counsellors as well as healers. The success of their counselling and their medicine reflected their position as intermediary between ordinary humans and the extra-ordinary influences which affected human lives, and it also reflected the patient's appreciation of that role, which was vital to successful healing.

Although native Indians are accustomed to visiting doctors' offices and hospitals, they have not turned away from their traditional medicine. During its hearings in the North, the Commission was urged several times to help the modern system of medicine recognize that sometimes the traditional system can complement it.

Commissioners learned that while people of native ancestry appreciate the expertise, knowledge and technology of modern medical and hospital services, some still want, for cultural, historical and spiritual reasons, to turn to a medicine man. Their relationship with that medicine man is characterized by supportiveness and understanding and is a very personal thing; it may vary from one person to another.

Because of the very personal nature of the medicine man's services, it would be inappropriate to suggest he become part of a highly regulated and organized health care system. On the other hand, the Commission believes the medicine man has a legitimacy in the health care setting, and he can complement the efforts of modern medicine. The Commission urges division councils and health professionals to acknowledge the contribution these traditional practitioners can make to the well-being of individuals, and to establish co-operative working relationships with them.

Employment Conditions and Benefits

The Commission recognizes that the proposal it makes for the organization and management of the health care system will have a profound effect on employees with respect to reporting relationships, memberships in employee organizations and procedures in contract bargaining. However, the Commission firmly believes that while these may provide challenges, they do not necessarily constitute obstacles to reforming the health care system in order to achieve principles leading to more effective health care in the future.

The Commission is aware that the several thousand employees involved in health care delivery are members of different unions and have their contracts negotiated by a number of different organizations. The Commission feels some new associations and processes may have to be considered and it believes that in this kind of context, the following principles are particularly important:

- that existing employment benefits are maintained to the greatest degree possible wherever there is a change in employers.
- that every means is taken to ensure the retention of job security and seniority when a change of employers occurs.
- that provincial uniformity be maintained in all aspects related to employment contract provisions in order to avoid serious discrepancies developing between different divisions.
- that means be developed for involving employee groups to achieve an acceptable basis for possible adjustments in memberships in unions and other employee organizations.

To ensure these principles receive the proper consideration, the Commission is of the opinion certain mechanisms must be established. Perhaps one of the most important ones is that collective bargaining should be done on a provincial basis so uniform contract provisions concerning salaries and other benefits exist for all professional and support personnel. The Commission is generally supportive of an arrangement whereby a major health care organization, such as the Saskatchewan Health-Care Association or the Saskatchewan Association of Special Care Homes, in partnership with the Department of Health, negotiates contracts for such groups as nurses, therapists, maintenance workers, emergency medical technicians and others.

However, the Commission also believes some special provisions may be necessary to act as incentives in recruiting personnel to more remote and isolated areas of the province. In a special way, this would apply to Northern Saskatchewan where an inter-division incentives recruitment package could be developed. Therefore, division councils must be left with a degree of flexibility to enhance basic contract provisions in order to meet local circumstances.

SUMMARY OF RECOMMENDATIONS

1. A Consumer-Controlled Health Care System

1.1 **The province should be divided into 15 comprehensive HEALTH SERVICES DIVISIONS for the purpose of organizing and delivering health care services and which will result in a system characterized by integration of services and continuity of care.**

- (a) The divisions should be determined in this way:
    - (i) Ten rural divisions to deliver services to their residents.
    - (ii) Two large urban divisions to deliver services to residents of Regina and Saskatoon plus certain selected services for the entire province.
    - (iii) Three northern divisions with programs uniquely designed to serve the needs of northern residents. (Refer to Section 6).

1.2 **The 10 rural divisions should be set up on the basis of such factors as existing health care resources, geographic features, travelling patterns for services, and cultural and historical relationships.**

- (a) Their populations should range between 40,000 and 80,000.
- (b) Their boundaries should be drawn along existing rural municipality boundaries to avoid splitting R.M.s between divisions. The Commission suggests boundaries as shown on a map at the end of this section.
- (c) Within each division, five or six electoral subdivisions should be established, depending upon population and geographic considerations.

1.3 **Two large urban divisions should be established for Saskatoon and Regina, responsible for providing basic health care services for their residents as well as more specialized types of care (involving advanced technology and highly specialized training) to the population of the whole province.**

- (a) The two urban divisions should have boundaries corresponding to the officially designated limits of each city.
- (b) Residents of the two rural divisions immediately adjacent to Regina and Saskatoon should continue to receive health services in the respective cities, on the basis of contracts between the urban and rural divisions.

1.4 **A health care authority known as the HEALTH SERVICES DIVISION COUNCIL must be established within each of the 12 divisions in rural and urban Saskatchewan to manage the health care programs within its mandate.**

- (a) The division council for a rural division should consist of 10 to 12 members elected for a three-year term by its residents, on the basis of two councillors from each subdivision.
- (b) The large urban divisions (Saskatoon and Regina) should be represented by a total of 12 members, including two representatives from the rural divisions and, on the Saskatoon council, one representative from the three northern division councils, with the remaining members being elected at large within each city.

1.5 **Each rural and urban division council should be chaired by an elected councillor selected by his/her colleagues at an annual organizational meeting.**

(a) The chairperson should be appointed for a one-year term with eligibility for re-appointment without a limit on the number of terms.

1.6 **Division councils must have the authority and responsibility for all aspects of health care, including program planning, evaluation, budget allocation and management, and arrangements to deliver acute care, ambulance services, long-term care, community-based services, and mental health.**

(a) The programs to be included within the division councils' mandate should be designated by the government through the Department of Health.

(b) The councils would also be responsible for:

  (i) accountability to their residents, and to the Minister of Health, for financial management and program delivery within the division.

  (ii) accountability to the Department of Health for the appropriate use of public funds allocated for the provision of adequate health care services within the division.

(c) The division councils would employ all senior management, institutional management, professional, supervisory and health care delivery staff.

(d) The councils would become the owners of all publicly-owned health care facilities within their boundaries.

(e) The councils would continue to respect the private nature and ownership of hospitals and long-term care centres operated by religious communities, church organizations or health care corporations, and make contracts with them to provide services to the division.

1.7 **In addition to their normal responsibilities to their own residents, the division councils of Regina and Saskatoon should also be responsible for more highly specialized hospital care and generally for the highly sophisticated services which are to be provided to residents throughout the province.**

(a) Certain highly specialized services for the total population should be available in both divisions.

(b) The most specialized services should be rationalized, with some available in Regina and others in Saskatoon.

1.8 **Each division council must establish a management structure which enables its mandate to be carried out in the most effective and efficient way, with the highest degree of financial accountability, and which ensures that a comprehensive range of services is delivered in a manner consistent with the principles underlying quality care.**

(a) The management staff should consist of a chief executive officer with a direct reporting relationship to the council and responsibility for ensuring that a team of professional and administrative staff is available to serve at the various levels of the system.

(b) To advise it on the major programs, each division council should appoint standing committees, chaired by division councillors and comprised of representatives of the division council, health care professionals and consumers.

1.9 Division councils must have authority and responsibility for the financial management of health care programs and services assigned to them and must determine operating plans and priorities, allocate resources and distribute funds in accordance with their own budgets.

(a) The major source of funding must be the Department of Health and the allocation to each division must be determined on the basis of uniform provincial guidelines and recognition of any needs and circumstances peculiar to a division.

(b) Provincial funds must be allocated to each division on a global basis and each division council must be responsible for determining its priorities for allocating funds to different programs and services, reflecting the special needs and directions of the division.

(c) The budget of each division council must be determined on a per-capita basis, taking into account the total population, age and sex distributions, epidemiological considerations, socio-economic status, and the required scope of services provided by the council.

1.10 Each division council's budget must reflect and incorporate a commitment to quality health care according to provincial principles and standards, but also recognize the need for long-term planning, and for reflecting special circumstances or needs within the division.

(a) Each division council must submit to the Department of Health a three-year plan which identifies budgetary plans and priorities for various purposes. The Department should make its funding allocations on a yearly basis related to the three-year plan, with annual adjustments as determined by changing circumstances.

1.11 Division councils' financial policies must be founded on principles which reflect outcomes measurement, operational incentives and management accountability.

(a) Division councils must ensure that adequate monitoring of financing takes place so that if difficulties exist, they can be discovered early and action taken through consultation with the Department of Health to correct them.

(b) The Department of Health must have legislation which would permit the Minister of Health to appoint a public trustee for a division council which has been unable to manage its budget effectively and produces serious financial difficulty for the division.

1.12 Division councils should be permitted to retain any surpluses at the end of a fiscal year and use them in accordance with uniformly-established guidelines developed by the Department of Health in consultation with division councils.

1.13 To ensure adequate funding for an integrated and comprehensive health care program, legislation and policies must be developed by

the provincial government as well as by division councils which define the basis on which division councils will obtain funds and decide on their allocation.

(a) Provincial legislation must identify the total spectrum of health programs and activities which division councils will be responsible for delivering and which will be funded by the Department of Health.

(b) The legislation should permit division councils to raise funds through a municipal levy for special program initiatives or for any special needs that help them maintain a sound budgetary position. Revenues raised through such a levy should not exceed 5% of the provincial allocation.

(c) Legislation should give the councils the authority to undertake fund-raising for supplementary projects and initiatives beyond the basic health care services, with the approval of the Department of Health.

(d) Division councils should permit institutions to establish retail-type revenue-producing operations which provide a benefit or convenience to patients, friends, families and staff, but which do not require program funds to keep them viable.

1.14 **Each division council must develop a five-year capital plan for construction, furnishings and equipment required for acute care, long-term care, mental health, ambulance units and other facilities, including those which are privately owned.**

(a) The long-range capital plan must be submitted to the Department of Health for its consideration and approval, resulting in the division's capital program strategy for a specified five-year period.

1.15 **The provincial share of funding for construction of a new institution, expansion of an existing facility and the initial equipment and furnishings for such facilities will be determined by their category and mandate.**

(a) The provincial share of construction funding will be 95% of approved cost for base hospitals.

(b) The provincial share of construction funding for all other facilities will be 80% of approved costs.

(c) The provincial share of equipment and furnishings for all new construction will be 100% of approved costs.

1.16 **Each division council must establish a capital reserve fund for replacing furniture and equipment and renovating facilities, and must receive an annual capitation grant calculated by the Department of Health for the purpose of maintaining the fund at a level appropriate to the facilities under the council's jurisdiction.**

(a) Replacements and improvements must be funded equally by a division council and the Department of Health, each paying 50% of approved costs.

1.17 **A DIVISION COUNCIL CO-ORDINATING BOARD must be established, consisting of the chairpersons of the 15 division councils, to facilitate communication, liaison and co-operation among the divisions and with the Department of Health, provincial agencies, and the Health Analysis and Development Commission. (See Section 5).**

(a) The board should select division council representatives to various provincial boards such as the Saskatchewan Cancer Foundation.

(b) The board should develop policies and practices for the inter-divisional delivery of health services, providing formal linkages between institutions wherever appropriate.

(c) The board should have a formal reporting relationship with the Health Analysis and Development Commission so it can co-operate in the provision of information and receive analysis based on research undertaken by the commission.

(d) The board should develop strategies for liaison with various agencies associated with the health care field, including educational institutions, Department of Health branches, and advisory groups.

(e) The board should meet regularly as determined by its agenda, but not less than twice a year.

1.18 To implement the divisional system for managing and delivering health care services, a special transition unit should be established in the Department of Health with the status of a branch, reporting directly to the Deputy Minister and containing expertise on organizational development, strategic planning, resource allocation, legislation, funding and administration.

(a) The transition unit should propose to the Department of Justice drafts of the necessary legislation to establish the proposed divisions and assign responsibilities to the division councils.

(b) The transition unit should identify for the Department of Justice the various acts pertaining to institutions, community-based programs and health professionals which may need revision as a result of the establishment of division councils.

(c) The transition unit should provide the resources to set up the initial council in each division, and help it establish its administrative organization.

(d) The transition unit should develop training and orientation programs for newly-elected councillors and their management staff.

1.19 The Department of Health must be instrumental in developing polices to ensure that employees who now work for a variety of agencies retain their benefits and levels of compensation to the greatest degree possible when they become employees of the division councils.

1.20 The Department of Health should provide ongoing leadership by establishing the principles of health care delivery in the province; by planning, evaluating and priorizing health programs at the provincial level; by serving as an advocate within government for public policy and funding support for health; and by providing administrative and program consultation and support to the division councils.

1.21 The Department of Health should continue to have direct responsibility for certain programs and services which are more appropriately considered in the total provincial context than as part of the division program.

(a) The Department should directly deliver such programs as the Saskatchewan Hearing Aid Plan, the Provincial Laboratory, and Vital Statistics.

(b) The Department should provide direction for health promotion initiatives in the province, and initiate and deliver activities which require a provincial thrust.

(c) The Department should have total funding and administrative responsibility for payments for all insured programs which include physicians, chiropractors, and optometrists, as well as the Children's Dental Program and the Prescription Drug Plan, and should develop reporting mechanisms to regularly provide the division councils with information on service utilization.

(d) Provincial agencies responsible for delivering programs related to cancer and alcohol and drug abuse should continue to be accountable to the Minister of Health.

1.22 **The Department of Health should continue to establish, monitor and regulate basic health standards to ensure that services provided by facilities and programs meet minimum standards, and that public health and safety are protected.**

2. Emphasis on Community and Supportive Living Services

2.1 **The Department of Health must establish a set of specific health targets which would be the foundation for provincial programs, initiatives and budget priorities, and which would serve as a guide to division councils in establishing their health promotion and other programs.**

(a) Such targets should be specified for achievement over five-, 10- and 15-year periods.

(b) A major factor helping to determine such targets should be the health status surveys done by the Health Analysis and Development Commission (See Section 5).

(c) Funding policies should be developed by the Department of Health which encourage each division to take imaginative initiatives to achieve health targets.

(d) Such targets should be specific and should identify risk factors contributing to illness and mortality rates in areas such as traffic accidents, lung cancer, breast cancer and heart failure.

2.2 **Each division council should develop strategies to meet provincial health targets, identify specific targets which particularly reflect the needs of its area, and develop programs and initiatives involving communities and individuals in activities designed to achieve those targets.**

(a) Councils should develop a system of initiatives to encourage communities to try innovative approaches to achieve the specified targets.

2.3 **The Health Analysis and Development Commission (See Section 5) must have as one of its responsibilities the monitoring of provincial and local government policies and initiatives which are outside of the health care field but which can, when implemented, have an adverse effect on the health and well-being of Saskatchewan residents.**

(a) The Commission's annual report to the legislature should refer to and, where appropriate, express caution about industrial, commercial and public undertakings which could undermine good health.

2.4 **The Health Analysis and Development Commission should undertake a health status survey of the Saskatchewan population every five years to evaluate the effectiveness of programs undertaken to improve health and to determine those groups within the total population which might be at particular risk and require special programs.**

(a) The insights gained from the health status surveys should form the basis for program changes at the provincial and division levels.

2.5 **A comprehensive, co-ordinated and integrated program of community health and supportive living services, focused on promoting health and fostering independent living, must be developed in each division to meet as many health needs of the total population as possible.**

(a) The total community health services program package should incorporate the elements now found in public health, chiropody, community therapy, and health promotion.

(b) The program must be expanded to include home care, community mental health services, support for family caregivers, and aids to independent living to further reduce the dependence on institutional care.

2.6 **A community health services unit should be established in each division to plan and direct the various programs which require specially-trained health professionals, and to co-ordinate community services with hospitals and supportive care centres (Refer to Recommendation 3.30) on behalf of the consumer.**

(a) The head of the community health services unit would be a program director reporting to the chief executive officer of the division council.

(b) The professional team should include people trained to deliver nursing, rehabilitation, inspection, health promotion and education, mental health, counselling, and home support services.

2.7 **Each division should establish a standing committee on community health services to ensure those services are highlighted in its programs and delivered in a responsive and co-ordinated way.**

(a) The division council should appoint one of its members annually to chair the committee, which should include representatives of professional and community groups with special interest in public health, home care and rehabilitation services, and a representative from the mental health advisory committee. (Refer to Recommendation 2.41).

(b) The committee, consisting of seven to nine persons, should be appointed by the division council for a three-year term.

2.8 **A mechanism should be established within the community health services unit of each division to provide a convenient entry point for people requiring supportive living services at home and/or supportive care centre placement, and to assess their needs, abilities, and the supports available to them in order to determine their unmet needs.**

(a) Provincial assessment criteria should be developed jointly by the Department of Health and the Division Council Co-ordinating Board.

(b) Each division should designate an administrator of assessment responsible for:

  (i) setting up local assessment teams consisting of professionals from the hospital, long-term care, therapy and mental health sectors.

  (ii) administering policies for managing complex cases, placement in supportive care centres, delivery of respite care and palliative care.

(c) Each assessor should be required to complete an assessment training program offered by the Department of Health which is directed at developing assessment skills and knowledge, and which is based on a provincially-applied assessment policy.

2.9 A toll-free telephone line should be established under the auspices of the community health services unit of each division to provide health consultation and health services information to residents.

2.10 To enrich the personal dimension of the supportive living programs offered and to encourage a sense of neighborly responsibility, each division must encourage, organize and co-ordinate community volunteers.

2.11 The mandate of the traditional public health programs should be expanded to place much more emphasis on health promotion and maintenance of good health, through such programs as disease prevention, public education, personal and group counselling, and monitoring of environmental and community factors which affect the health of individuals.

(a) These specific services should be targeted at increasing people's sense of responsibility for preserving the health of their community and their personal good health.

2.12 Each division should take a team approach to the delivery of public health services to ensure co-ordination and integration, and should foster increased personal knowledge of the many factors which affect health.

(a) The core health professional team should include a medical health officer, nurses, environmental health officers (public health inspectors), nutritionists, health educators, and dental health educators.

(b) The numbers of staff, particularly in health education and nutrition, should be increased to enable these health professionals to play a greater and more effective role in health promotion.

2.13 The medical health officer employed by each division council should have overall responsibility for the focus and direction of public health services within the division, with special emphasis on strategies for disease prevention and health promotion.

(a) The medical health officer should have specialized training in the public health field.

(b) The medical health officer must have responsibility and authority for enforcing the provisions of The Public Health Act.

2.14 A community nursing program should be developed which serves both the public health and home care components of the community-based program, and provides an integrated and co-ordinated approach in the delivery of services to the total population, from pre-school children to seniors.

(a) The community health nurse's mandate should be defined in a broader way to ensure the same person may provide a variety of basic nursing services in a particular community or situation. For example, a community health nurse on a post-natal home visit may also attend to the needs of an infirm senior in that home.

(b) The services of community nurses should be delivered through a variety of activities and settings, including schools, special clinics, public lectures, group counselling, and home visits.

2.15 The public health inspector's role should be expanded to clearly indicate a responsibility to monitor, inform and educate about a broad spectrum of environmental factors in the immediate community which affect the health of individuals.

(a) The position of public health inspector should be renamed environmental health officer.

(b) Training and in-service programs should include environmental issues.

(c) Major industrial and commercial projects should remain a provincial responsibility attached to the Department of Environment and Public Safety.

2.16 The public health team of each division must include a health education officer(s) responsible for developing health information, promotion and counselling services, having direct contact with individuals, groups and institutions within the community, and serving as a resource person to other health care professionals.

(a) The health education programs developed for a particular division must reflect its special needs and priorities.

(b) The health education officer should involve other health care professionals in the division as resource persons to conduct clinics, provide counselling, and give presentations about the division's health education priorities.

2.17 Each division council should develop and implement detailed health promotion strategies which are specifically designed to improve the health of its residents and which provide for broad community involvement.

(a) Division health promotion strategies should complement and supplement the provincial strategy which is the responsibility of the Department of Health.

2.18 The Department of Health should allocate adequate funding for all health promotion activities in the province, based on department and division council plans for a dynamic program focusing on the maintenance of good health by each citizen.

(a) The total provincial health promotion fund should be determined on the basis of $10 per capita.

(b) The allocation to division councils for their overall promotion programs and specially-designed initiatives should amount to 50% of the total health promotion fund.

2.19 Division councils should be sensitive to the special needs of such groups as natives, children and adolescents, and various ethnic groups in accessing health services, and should develop ways to help them receive services and maintain good health to the greatest degree possible.

(a) Division councils should employ native liaison workers on the basis of the assessed special needs of their native populations to provide a link between native clients and the health care system; to assist natives to get health services; to provide follow-up to treatment; and to educate natives about healthy lifestyles.

(b) Division councils should work with local ethnic organizations to encourage their volunteer involvement in assisting ethnic residents to obtain health services and information.

(c) Information and counselling services available for children and adolescents should be widely publicized so youth and parents can comfortably and conveniently access services.

2.20 **Each division council should offer a community therapy program as part of its community-based services package designed to meet the special needs of all division residents, with a core team of physical therapists, occupational therapists, and speech and language pathologists.**

(a) Community therapy services should be provided on an outreach basis to community hospitals, supportive care centres, family health care centres and private homes.

2.21 **A clear policy and understanding should be developed between each division council and the school boards within the division, stipulating that community therapy services for pre-school children and adults and all institution-based therapy services are the responsibility of the division council, and services to school-age children outside of health care institutions are the responsibility of the respective school boards.**

(a) Each division council should develop a co-ordinating and monitoring mechanism with the school boards in the division to ensure services are co-ordinated and gaps do not occur.

2.22 **To ensure an adequate supply and mix of community-based rehabilitation personnel, each division should establish criteria for determining staff levels for therapy positions, which take into consideration the total population and special circumstances peculiar to that division.**

2.23 **To enhance and ensure adequate delivery of physical and occupational therapy services, the therapy team should include therapy technicians who would provide services under the direction of professional therapists. (Refer to Recommendation 4.46).**

2.24 **Division councils should be responsible for acquiring and distributing equipment provided through the Saskatchewan Aids to Independent Living (SAIL) program for use by individuals residing in private homes, group homes and supportive care centres.**

(a) The Department of Health should be responsible for centralized purchasing and for a central warehouse and repair depot.

2.25 **The home care program in each division should provide a full range of health care and other supportive living services to all residents, including the elderly, the young disabled, the mentally handicapped, the mentally ill and those with head injuries, who require these services to remain independent and at home for as long as possible.**

2.26 **The home care program in each division should include nursing, home support, and rehabilitation services delivered through a combination of staff and volunteers recruited by the home care program as well as other community-based programs and agencies.**

(a) The core services provided should include:
  - Nursing services: administration of medication, intravenous therapy, and health counselling.
  - Home support services: homemaking, home maintenance, personal care, mental health support, emergency monitoring and response systems, friendly visiting, meals on wheels, transportation and in-home respite services. (See next chapter, Support to the Family Caregiver).
  - Rehabilitative services: physical therapy, occupational therapy, speech and language pathology. (See previous chapter, Therapy and Rehabilitation Services).

(b) Home support services should be provided by personnel and volunteers recruited by the home care program, whereas nursing and rehabilitation services should be co-ordinated with and made available through the community nursing and community therapy programs.

2.27 User fees for home care services, based on the principle of accessibility, should be established on a province-wide basis to ensure equity for clients and division councils.

(a) There should be no charges for nursing and rehabilitative services.

(b) There should be charges for certain home support services such as home maintenance and meals on wheels.

2.28 To provide a sense of security to caregivers and dependent people living at home, personal emergency response systems - electronic devices which connect their wearers with the nearest hospital or other designated emergency monitoring centre - should be introduced as part of the home care program within each division.

(a) Division councils should develop a plan for a reasonable monthly charge to users of personal emergency response systems.

2.29 Each division council should develop, as part of its home care program, a comprehensive support system for family caregivers which is specifically targeted to the caregiver and provides access to respite services, counselling and educational services.

(a) Support services should be made available to caregivers of the elderly, physically disabled, mentally handicapped, head injured, and mental health clients.

2.30 A health care co-ordinator within the home care program should be assigned as the primary contact for each family caregiver, to regularly communicate with and counsel the caregiver to ensure his or her needs are met, and to help obtain necessary services for the dependent individual.

2.31 Each division council should ensure that a wide range of respite services is available and accessible to all family caregivers on the basis of assessed and varying needs, and recognizing the unique care and social needs of the dependent individual.

(a) Division councils could locate respite beds in a variety of settings such as supportive care centres, licensed private care homes, comprehensive family health care centres and other designated health care facilities, and on a limited basis in community hospitals, depending on the availability of such facilities and on the caregiving needs of the communities.

(b) Respite services should be available within the caregiver's home, whenever this is more practical or advantageous.

(c) Respite services should be available on short notice, and for periods ranging from a few hours to three to four weeks, and during nights.

(d) Criteria for the receipt of respite services should be developed within each division, based on the assessed and recognized needs of the caregiver and with no restrictions based on the age or disability of the dependent individual.

2.32 **To alleviate the stress caregivers experience because of their concern for the proper care of dependents, educational and counselling services should be provided through the home care program in each division.**

(a) Educational services may include workshops which focus on caregiving techniques, handling stress, and other related topics.

(b) Counselling support services provided by professionals such as mental health workers, social workers, and nutritionists should be made available and co-ordinated through the health care co-ordinator.

2.33 **For daily relief for family caregivers and to provide dependent adults with social, recreational and rehabilitative opportunities, adult day/night care centres reasonably accessible to families requiring such services should be established in each division.**

(a) Adult day/night care centres may be located in a number of settings, including family health care centres, seniors' complexes and other designated community facilities.

(b) Provincially established standards should be developed to ensure minimum program and staffing requirements are met.

2.34 **Division councils should establish a system of fees for respite and adult day care which will not, however, create an incentive for institutionalization and which do not exceed resident charges at supportive care centres.**

2.35 **A comprehensive palliative care program should be developed within each division with a range of services for home support, pain and symptom control, psychological care and bereavement aimed at meeting the needs of the terminally ill and their immediate family and friends.**

(a) Palliative care should be available in a number of settings, but most particularly at home, in community facilities offering health care services, and in community hospitals.

(b) The program should facilitate movement of the patient between home and hospital, as the patient's and caregiver's needs change.

(c) Consultation or "symptom control" teams of clergy, nurses, physicians, social workers and others with skills in the care of the dying should be established in each division to provide inpatient and outreach counselling and advice to patients and families.

2.36 **An ENRICHED HOUSING COMMITTEE should be established by the Saskatchewan Housing Corporation within each health services division to co-ordinate housing initiatives, and to make recommendations about development of housing programs and construction of housing.**

(a) Each eight or nine-member committee should include three representatives nominated by the division council, and one representative from a community housing authority in each sub-division.

(b) The committee chairperson should be selected by the Saskatchewan Housing Corporation.

(c) Each committee should seek division council endorsement of its housing strategies before making recommendations to the Saskatchewan Housing Corporation.

2.37 **A new provincial organization entitled the SASKATCHEWAN MENTAL HEALTH COMMISSION should be created for the purpose of recommending provincial initiatives in mental health; monitoring mental health services in the province; establishing mental health standards; sensitizing the public and decision makers regarding mental health issues; and serving as an advocate for both mental health clients and service providers.**

(a) The 10-member Commission should be comprised of five chairpersons of the division council mental health advisory committees, named by the Division Council Co-ordinating Board; the Professor and Head of Psychiatry, University of Saskatchewan; and one representative of each of the Saskatchewan Branch of the Mental Health Association, the Saskatchewan Psychiatric Nurses Association, the Saskatchewan Psychologists Association, and the Saskatchewan Association of Social Workers.

(b) Appointments should be for three-year terms, with eligibility for reappointment for a second term.

(c) The Commission should elect its own chairperson annually.

(d) The Commission should serve in an advisory capacity to the Minister of Health and the Division Council Co-ordinating Board, and should submit to both an annual report on its activities, observations and analyses, and its recommendations.

2.38 **The Department of Health, in partnership with the division councils and the Saskatchewan Mental Health Commission, must develop a mental health plan of action which extends over the next decade, and which results in the transfer of responsibility for the delivery of mental health programs and services from the provincial to the divisional level.**

(a) Institutional care, outreach and community-based programs and services, which are now the responsibility of the Department of Health, must become the responsibility of individual division councils.

2.39 A network of psychiatric institutional care should be developed by the Department of Health and the division councils which will provide for varying levels of treatment and rehabilitation services throughout the province to meet the many different needs of the mentally ill.

(a) A 12-15 bed evaluation unit, with one stream for adults and another for children and youth, should be established in conjunction with the University of Saskatchewan for early intervention in the most difficult cases.

(b) A special needs assessment and rehabilitation unit with 15-20 beds should be developed at the Wascana Rehabilitation Centre in Regina for younger seriously cognitively impaired individuals with mental handicaps or other disorders.

(c) A 15-20 bed special needs assessment and rehabilitation unit should be established at the Parkridge Centre in Saskatoon for elderly persons with cognitive impairments and related special needs.

(d) Residential units, with appropriate supportive living services, should be established within each division, with 20 beds in each of the Saskatoon and Regina divisions designated for those mentally ill persons from northern and southern Saskatchewan, respectively, who have special intensive needs.

2.40 Saskatchewan Hospital North Battleford should be designated as a forensic mental health facility for young and adult offenders, and no new residents should be admitted there except for those admitted through a lieutenant-governor's warrant, and others requiring a forensic mental health program.

(a) Division councils should become directly responsible for providing residential and institutional care to those mental health clients who normally would have been admitted to Saskatchewan Hospital North Battleford (with the exception of forensic patients).

(b) Mentally handicapped patients, dually diagnosed as suffering from mental illness, should be admitted to the Valley View Centre in Moose Jaw.

2.41 Each division council should establish a SPECIAL MENTAL HEALTH ADVISORY COMMITTEE as part of its administrative and delivery system, in order to facilitate co-ordination and integration with other community services and maximize public awareness and sensitivity to mental health issues.

(a) The advisory committee should consist of representatives of the general public, interest groups, and health professionals, and should be chaired by a division councillor.

(b) The primary role of the advisory committee should be to serve as an advisory body to the division council and as an advocate on behalf of patients.

2.42 Each division council should develop a mental health charter which would provide the basis for its strategy in addressing the needs of the mentally ill in its communities.

(a) The basic principles in the charter should include the following:
  - Recognition of the multi-dimensional nature of mental illness, and that individual citizens have differing and changing needs.
  - Recognition of the legal rights of mental health clients.
  - Commitment to the integration and mainstreaming of mental health services.
  - Commitment to a community-based approach in the delivery of services.

2.43 **Each division council should develop a well-defined and long-term plan for the provision of mental health services, which includes a range of community-based supportive living, rehabilitation, community outreach, outpatient, and acute inpatient treatment services, as well as a public education strategy to increase public sensitivity and understanding of mental illness.**

(a) An interdisciplinary team approach to the delivery of services should be adopted which provides for the involvement of a wide range of professionals, including psychiatrists, psychologists, family physicians, psychiatric nurses, social workers, and other community-based personnel, such as home care workers and therapists.

(b) To direct its mental health program, each division council should directly employ a psychiatrist, supported by an appropriate mix of professional and paraprofessional staff, including psychologists, psychiatric nurses, social workers, occupational therapists, recreational therapists, and community mental health workers.

(c) A strategy involving employers in the private and public sectors should be developed within each division to assist in the re-entry of the mentally ill into the mainstream of the workforce.

(d) Division councils should enter into twinning arrangements with each other to facilitate the provision of specialized services.

2.44 **To give mental health greater prominence at the local level, and to ensure an array of support services is available to community residents suffering from mental disorders, mental health programs and services should be mainstreamed with the health programs delivered by each division council.**

(a) Mental health services within each division should be co-ordinated and integrated with other health services, and most particularly with community-based services.

2.45 **Each division council must make a special effort to provide supportive living services to mentally ill individuals as part of its home care program, in order to assist them to live in a community setting, as independently as possible.**

(a) A class of paraprofessionals called **community mental health workers** should be established whose primary responsibility would be to provide home care support to the mentally ill.

(b) In most instances, the community mental health workers would be residents of the community, with training in a specially designed orientation program focusing on the needs of the mentally ill.

2.46 In order to revitalize mental health programs in the province, and to ensure adequate services and supports are available to the mentally ill, the provincial government must significantly increase the portion of health funding allocated to mental health.

(a) Increases in funding must be accompanied by corresponding increases in staffing and community support programs aimed at increasing the availability of services and their accessibility to mental health clients.

(b) As the division councils assume responsibility for mental health services, they must ensure that mental health programming and other community services which provide support to the mentally ill receive equitable funding and resource allocation in relation to other health programs.

3. New Thrusts for Institutions

3.1 **The mandates of hospitals in the province must be redefined to reflect the extent of services appropriate in various settings for the immediate and more distant future, and to ensure that roles of facilities of different sizes are complementary.**

(a) The redefinition must take into account the current level of services, the potential for expansion, the availability of professional and technological services, the population base served, and use of the facility.

3.2 **The examination and redefinition of hospital mandates must result in a classification of acute care facilities which will better serve community needs and ensure the most legitimate and appropriate services are available at various levels.**

(a) There should be three classifications, as follows:
  (i) Base hospitals
  (ii) Division hospitals
  (iii) Community hospitals
    - community A
    - community B

3.3 **The three hospitals in Saskatoon and the three hospitals in Regina should be designated as BASE HOSPITALS and should provide specialized expertise and services at the tertiary and quaternary levels for the province as a whole.**

(a) In addition to their referral roles, the base hospitals must provide basic hospital services to residents of Regina and Saskatoon and immediate environs.

3.4 **The major hospitals within each division should be designated as DIVISION HOSPITALS offering a wide range of secondary services, and serving as the major secondary care referral centres for the divisions in which they are located.**

(a) More specialized services would be provided by specialists recognized by the College of Physicians and Surgeons who would have privileges on an itinerant or permanent resident basis.

3.5 **Hospitals in the smaller communities in each division which have an average acute care daily census of 40 or less should be designated as COMMUNITY HOSPITALS offering a limited range of basic hospital services.**

(a) Hospitals with an average acute care daily census of 20 or more should be designated Community A.

(b) Hospitals with an average acute care daily census of approximately 10 to 19 should be designated Community B.

3.6 **The smallest hospitals, with an average acute care daily census of less than 10, should be revitalized into new multi-purpose facilities known as FAMILY HEALTH CARE CENTRES, providing a broad range of primary, outreach, outpatient and other services, in keeping with the changing health circumstances of the local population.**

3.7 **In order to occupy a position of regard and respect and to provide leadership and innovation in developing and improving health services, the three base hospitals in each of Saskatoon and Regina must articulate a unified and complementary mandate which clearly defines areas of medical and administrative expertise and co-ordination.**

(a) Without necessarily affecting the ownership of the hospitals, mechanisms must be found to move toward the co-ordination reflected in the concept of a "Saskatoon Hospital Complex" and a "Regina Hospital Complex".

3.8 **The combined mandate of the three base hospitals in each centre must reflect their special responsibility to the total patient population in the province to provide diagnosis and treatment which cannot realistically be provided in division or community hospitals.**

(a) Base hospitals must also provide a wide range of secondary services for the people living within the two cities and their immediate vicinities.

3.9 **Rural division councils and the Regina and Saskatoon division councils must develop formal agreements for the base hospitals to share expertise with and extend services to the division hospitals so their roles can be enhanced, resulting in more people obtaining specialized services closer to home.**

(a) Two possibilities for formal twinning which should be investigated are itinerant specialty visits and diagnostic support through sophisticated communications technology.

3.10 **The Regina and Saskatoon division councils should pursue joint ventures among their respective base hospitals as future services, programs and policies for the delivery of acute care services are developed.**

(a) Joint ventures could include medical transportation and the establishment of hostel units as an alternative to hospitalization for people from outside the city who have been referred for diagnosis, treatment or day surgery.

3.11 **The division councils responsible for the base hospitals must enter into formal affiliation agreements with the health science faculties at the University of Saskatchewan and the Saskatchewan Institute of Applied Science and Technology for the purpose of developing educational and research initiatives involving all the base hospitals.**

(a) Such formal agreements should provide an opportunity for undergraduate and postgraduate experience in selected specialty areas existing in each of these hospitals.

3.12 **Based upon the defined roles for each base hospital and the specialized services within each, the division councils in Saskatoon and Regina must develop joint formal medical manpower plans which underlie efforts to recruit specialists and subspecialists, and determine hospital admitting privileges.**

(a) A medical manpower plan should generally take into account epidemiological and demographic trends, identifiable health needs of the provincial population, and the development of hospital services in the longer term.

3.13 Division councils must examine the relationship between general practitioners and base hospitals, particularly in terms of the privileges of general practitioners in the expanding secondary and tertiary roles of these hospitals, and the increasing number of practices being established in the base cities, with a view to determining the appropriate number of privileges granted.

(a) Policies should be developed to provide guidelines for determining the number of general practitioner privileges appropriate to each base hospital.

3.14 The designation of division hospital should be adopted with a mandate to make available to residents of rural divisions a reasonable range of secondary hospital services, so they have ready access to such care with a minimum of travel.

(a) The range of services provided by medical specialists recognized by the College of Physicians and Surgeons could include general surgery, anesthesia, pathology, radiology, internal medicine and obstetrics.

3.15 In all divisions, certain acute care facilities which realistically can provide the approved range of secondary services should be designated as division hospitals, and serve residents as the major referral centres for these services.

(a) In some divisions, it would be appropriate to designate certain hospitals as co-division hospitals which share responsibility for secondary hospital services.

(b) Each of the proposed Northern Saskatchewan divisions should have a designated division hospital offering a broader range of services than those in rural divisions in southern Saskatchewan. (Refer to Recommendation 6.10).

3.16 Rural division councils should develop formal agreements with the College of Medicine for residency training in their designated division hospitals to ensure the College has a presence in institutions outside the two largest urban centres.

(a) The residency training might be most appropriate in areas such as family practice, general surgery, internal medicine and obstetrics, provided that medical staff with teaching expertise are available. (Refer to Recommendation 4.23).

3.17 Each division council with a designated division hospital must have a formal medical manpower plan which is related to the hospital's mandate and the total hospital services provided within the division.

(a) The manpower plan should be directed at enhancing the role of the division hospital as a referral centre and ensuring continuity and stability of service.

(b) The plan should provide for specialist services extended from the base hospital centres according to a formal agreement.

(c) The plan should also provide for the granting of privileges in a division hospital to physicians practising in the smaller community hospitals in the areas it serves.

3.18 **Rural division councils must develop and adopt pro-active plans for recruiting suitably qualified physicians to practise in the communities where division and co-division hospitals are located.**

(a) Medical practitioners located in division hospital centres must develop policies and practices designed to attract specialist colleagues to complement their practices.

3.19 **A province-wide plan for rationalizing services in hospitals with an average acute care daily census of 40 or less must be developed and uniformly adopted throughout Saskatchewan, taking into account the appropriate range of acute care services, the population served, current utilization patterns, and the availability of professional staff.**

(a) All hospitals with an average acute care daily census of 20 or more should be put in the proposed community A designation.

(b) All hospitals with an average acute care daily census of 10 to 19 should be put in the proposed community B designation.

(c) The mandates of all hospitals with an average acute care daily census of nine or less should be redefined to more adequately serve the population mix in their areas, and they should be designated family health care centres.

3.20 **Those hospitals designated community A should be able to provide such services as basic radiology and laboratory testing, limited medical and surgical services (general medicine, geriatrics, uncomplicated obstetrics), and primary emergency care.**

(a) The criteria for community A designation should include accreditation by the Canadian Council on Health Facilities and a medical staff of at least three fully-qualified physicians.

(b) Physicians resident in neighboring communities should be granted privileges in these hospitals.

3.21 **Community B hospitals should offer services similar to those of the larger community A hospitals, but with greater limits on obstetrical and surgical services.**

(a) The criteria for the designation of community B hospitals should include accreditation by the Canadian Council on Health Facilities and a strong preference for a medical staff consisting of at least two physicians.

(b) To meet the medical staff criterion, privileges should be granted to physicians resident in neighboring communities.

3.22 **The Department of Health and division councils should together develop plans for revitalizing the smallest hospitals (average acute care daily census of nine or less) into family health care centres, creating a provincial network which offers a broad range of primary health services throughout rural Saskatchewan.**

(a) The family health care centres should be headed by primary care nurses and should not be dependent upon doctors being resident within the community, but could have regularly scheduled visits by medical personnel.

(b) The core services offered at each family health care centre would fall into three major categories:

  (i) Basic nursing services - emergency, home support, public health, mental health.

  (ii) Visiting health professionals - physicians, psychiatrists, psychologists and other mental health professionals, physical therapists, speech and language pathologists/audiologists, occupational therapists, dietitians/nutritionists, chiropodists.

  (iii) Health education and fitness - well-baby clinics, well-seniors clinics, blood pressure clinics, health counselling services.

3.23 Each division council should designate two or three family health care centres as COMPREHENSIVE FAMILY HEALTH CARE CENTRES offering a more extensive program, selected on the basis of the population served, the proportion of seniors in the population, and convenience of location.

(a) Wherever integrated facilities exist, these should be designated as comprehensive family health care centres.

(b) In addition to the core services, the comprehensive family health care centres could provide expanded services for seniors, such as respite care beds, adult day and night care and temporary residential care, including temporary accommodation within the facility of people needing minimal acute care after hospitalization or for other specified purposes.

(c) The mandate of the comprehensive family health care centre could include providing shelters for battered women or abused children.

3.24 A sophisticated communications network should be developed by the Department of Health, in partnership with the division councils, and funded by the Department, to provide modern communications technologies to community hospitals and family health care centres so that consultation and advice from the larger centres can be made readily accessible to all facilities across the province.

(a) A basic communications network linking these institutions of differing size and mandate should include fax machines, ultrasound and radiographic equipment, cellular telephone equipment and other up-to-date technology as it becomes available.

3.25 A province-wide system must be developed to manage hospital utilization, taking into account standardized admission criteria for all acute care services, and it must form the basis for policies and practices of division councils.

(a) All elective admissions must be closely monitored to ensure they conform with criteria which justify admission.

(b) After admission, a standardized care protocol must be followed to ensure high quality and timely care practices.

3.26 A PROVINCIAL HOSPITAL UTILIZATION MANAGEMENT COMMITTEE must be established to develop appropriate criteria for all categories of hospitals, monitor these and propose revisions as appropriate to changing practices and advancing technologies and specialties.

(a) The provincial hospital utilization management committee should consist of two nominees from each of the College of Physicians and Surgeons, the Saskatchewan Registered Nurses' Association, the Saskatchewan Association of Health Services Executives, and the Division Council Co-ordinating Board. It would select one of its members to serve as a chairperson.

(b) The provincial hospital utilization management committee should request the College of Physicians and Surgeons to prepare a set of medical practice protocols which would form the basis of hospital utilization policies.

(c) The provincial hospital utilization management committee should be responsible for an ongoing review of utilization practices and policies and should submit its evaluations and proposals for any modifications in an annual report to the Department of Health, division councils and the Health Analysis and Development Commission.

3.27 In determining the hospital component of each division council's budget, the Department of Health must implement funding policies which ensure that every hospital fulfils its acute care mandate to the greatest extent possible.

(a) Such policies must recognize the measurement of intensity of service required, average length of stay and case mix.

3.28 Each division council must require the establishment of a UTILIZATION MANAGEMENT COMMITTEE for its division, community and base hospitals, which will develop policies to ensure the most effective utilization of acute care facilities, and monitor the application of those policies.

(a) Each division and base hospital should establish an institution committee consisting of representatives of the medical staff, nursing staff, auxiliary staff and administration.

(b) For all community A and community B hospitals within a division, a single division utilization management committee should be established, consisting of the chairperson of a division hospital utilization management committee, and one representative of the medical staffs, the directors of nursing and the hospital administrations.

3.29 Using provincially-adopted standards and objectives, each division council must develop a clearly-defined plan for providing services, programs and facilities required by residents designated as needing heavy long-term care.

(a) The division plan must take into account the heavy care needs of seniors with severe physical incapacities, younger members of society with serious physical disability, and the elderly with cognitive impairment.

3.30 All institutions whose primary purpose is providing services at Levels III and IV should be designated as SUPPORTIVE CARE CENTRES.

(a) All supportive care centres must have a rated bed capacity for Levels III and IV of at least 30 and must meet accreditation standards established by the Canadian Council on Health Facilities Accreditation.

3.31 The global budget of each division council should include an allocation from the Department of Health for Levels III and IV institutional care on the basis of a ratio of 160 beds per 1,000 people aged 75 and over.

(a) The ratio of 160 per 1,000 should include 25 beds for the severely cognitively impaired.

3.32 The severely cognitively impaired should be accommodated in residential units for five to seven people which should be located in a neighborhood residence or a specially-designed residential suite in an existing health care facility.

(a) The program should emphasize supportive interpersonal relationships and compassionate care in a low-stress environment.

3.33 The present integrated facilities should be designated as comprehensive family health care centres which would continue to provide accommodation for Levels III and IV residents and would develop outreach programs, including adult day/night care and respite care.

(a) The level of funding should be determined by the actual number of Levels III and IV residents, as well as the components of the expanded outreach program.

3.34 A detailed uniform classification system which clearly identifies the level and extent of care required by each resident in a supportive care centre, and a workload monitoring system, must be developed by the Department of Health for adoption by division councils as the basis for admitting residents, determining service levels and establishing staffing guidelines.

(a) Residents should be admitted to a supportive care centre only after assessment by division council personnel using the provincially-adopted classification system, and recognizing that community supportive living systems are no longer able to meet their needs.

3.35 Provincial authorities must proclaim and division councils must enforce regulations governing personal care homes to ensure they provide quality care and safe and comfortable surroundings for the residents.

(a) To ensure that operators of personal care homes have a knowledge of the physical and emotional supports that residents require, division councils should provide related orientation seminars and short courses.

3.36 Division councils must establish management committees for all larger health care institutions and for a combination of smaller ones, with representation from local citizens as well as health professionals.

(a) Each management committee selected by the division council should consist of seven to nine members representing residents of the areas served by the facility, and one representative from each of the medical and nursing professions.

(b) The management committee should be charged with responsibility for the day-to-day operation of the facility it represents, in accordance with the policies and priorities of the division council.

(c) In the smaller communities, a management committee should have responsibility for a combination of acute care and long-term care facilities.

3.37 **All hospitals and supportive care centres privately owned by religious or corporate agencies should continue their existing arrangements for the day-to-day management of their facilities, including appointment of their own boards of trustees and executive personnel.**

(a) Such boards of trustees would have day-to-day responsibility for ensuring the mandate of the institution they represent is carried out in accordance with agreements and understandings with the division council.

3.38 **A comprehensive and co-ordinated medical transportation system must be developed by the Department of Health, ensuring that a wide range of quality and cost-effective emergency and non-emergency transportation is available in an equitable manner throughout Saskatchewan.**

(a) Taking into account Saskatchewan's geography, the plan must provide for rationalization of air ambulance, advanced road ambulance, primary road ambulance and auxiliary transportation services (those not requiring sophisticated equipment).

3.39 **Each rural division council should be responsible for delivery of a co-ordinated and interlocking network of road ambulance and auxiliary transportation services within its division.**

(a) The medical transportation services in each division should have their headquarters at a division hospital which must ensure that advanced road ambulances with a mix of appropriately-trained emergency medical personnel and properly-equipped vehicles are always available to provide the best service in life-threatening situations.

(b) Divisions with co-division hospitals should select the most central location as the headquarters for the medical transportation service.

(c) Centres with small acute care facilities should be designated as satellite stations offering a primary road ambulance service which can be provided by part-time and volunteer staff trained in basic emergency care, preferably at the EMT level, and operating less sophisticated equipment.

(d) In most instances, primary road ambulances would transport their patients to satellite stations or the closest division centre.

3.40 **In Saskatoon and Regina, the division councils should establish MEDICAL TRANSPORTATION COMMITTEES responsible for providing a co-ordinated and integrated program of ambulance and auxiliary transportation services for the three hospitals in each city.**

(a) The medical transportation committees in Saskatoon and Regina should provide services to the Saskatoon and Regina rural divisions respectively.

(b) One of the base hospitals in each city should be designated as the medical transportation services headquarters for the division.

3.41 A division dispatching unit should be located in each hospital designated as headquarters for a division's medical transportation services.

(a) In Regina and Saskatoon, the base hospitals designated as the headquarters hospital for the service should assume responsibility for the dispatching system within the city and the rural division surrounding it.

3.42 A SASKATCHEWAN MEDICAL TRANSPORTATION AUTHORITY should be created to administer and operate the provincial air ambulance service and to develop and establish inter-divisional communications and dispatching links.

(a) The Saskatchewan Medical Transportation Authority should consist of seven members, with four representing division councils (including one from the North), one representing the College of Physicians and Surgeons, one representing the Saskatchewan Registered Nurses' Association and one representing the Saskatchewan Ambulance Association.

(b) A northern branch of the authority should be located in La Ronge in order to provide air ambulance and communication services specifically designed for Northern Saskatchewan. (See Section 6).

(c) The Saskatchewan Medical Transportation Authority should undertake to explore the possibilities and potential of a central response system for the province.

3.43 The Department of Health should establish a standard pickup and mileage fee for each level of medical transportation, capping ambulance charges regardless of distance, mode of transportation or patient age, to ensure consistency and equity in user charges among the divisions.

(a) The Saskatchewan Medical Transportation Authority should be consulted about any modifications in policies governing ambulance charges.

4. New Approaches for the Health Professions

4.1 **The Government of Saskatchewan must establish a PHYSICIAN SERVICES REVIEW PANEL with representatives from the Department of Health, the College of Physicians and Surgeons, the Saskatchewan Medical Association and the Division Council Co-ordinating Board to conduct an in-depth analysis of existing legislation, regulations and payment systems, with a view to permitting the development and introduction of more options for the practice of medicine.**

(a) The panel should have two representatives from each of the member organizations with an independent chairperson appointed by the Minister of Health.

(b) The panel must give priority to considering elements which would contribute to:

(i) the establishment of a system which would link three or more physicians in a complementary group practice.

(ii) the establishment of medical services centres (Refer to Recommendation 4.3) headed by physicians but involving other health professionals in the delivery of service as a team.

(iii) the clarification and affirmation of the legal and funding status of the four existing community clinics.

4.2 **The model for delivery of medical services in rural communities should be based on a group practice consisting of a minimum of three physicians, and providing for a "one practice in two or three locations" concept where this is the most feasible arrangement.**

(a) Division councils must group acute care and long-term care facilities into geographic units which encourage inter-relationship and integration of medical and related services.

4.3 **Legislation must be enacted to provide for the establishment of MEDICAL SERVICES CENTRES which would allow and encourage medical practices to adopt an interdisciplinary professional health team approach to providing primary care.**

(a) The entry point to such centres would be through the physician but could result in the prescription of other services, including psychology, nutrition, nursing and family counselling.

(b) Funding policies must be modified to ensure compensation for the professionals working as a team with the physicians.

(c) Medical services centres could be established by a division council to serve a particular community or geographic area, or by a group of family physicians who wish to provide broader services.

(d) Medical services centres must be established with the concurrence of the division council which would be responsible for approving and providing funding through annual grants.

4.4 **The Department of Health must develop regulations for the establishment and operation of "minor emergency" or "walk-in" clinics to ensure that specific criteria about the clearly identified need for such a service, the quality of patient care, and the avoidance of unnecessary "add-on" costs to the medical care system are taken into consideration.**

(a) No physician should be permitted to own, operate, or invest in an emergency clinic unless this is his or her full-time practice setting.

(b) Emergency or walk-in clinics must not be permitted to be established as a business operation by individuals outside the medical profession.

(c) "Moonlighting" by residents and interns in minor emergency clinics should not be permitted.

(d) A transition strategy must be developed to permit the phasing out of established clinics which do not meet the new criteria.

4.5 **The Department of Health must develop regulations which control radiology and other diagnostic services provided in minor emergency clinics and general practice offices, to ensure that such services are clinically justified, conducted by appropriately qualified professionals, and not needlessly duplicated in hospitals or radiologists' offices.**

(a) The College of Physicians and Surgeons must develop medical guidelines and standards for the use of radiology and other diagnostic services in settings other than hospitals and radiologists' offices.

4.6 **To ensure professional impartiality and independence in the referral of patients between general practitioners and specialist physicians, specialists must practise in settings distinct and apart from those of general practitioners.**

(a) Specialists who practise in association with general practitioners should receive the general practitioner fee rates for patients referred to them.

4.7 **Each division council must develop a division-wide recruitment strategy which takes into account social, professional and economic factors, with a view to attracting physicians to its area and ensuring a high degree of stability and continuity of specialist and general practice medical services for division and community hospitals.**

(a) Recruitment incentives, which could include start-up grants, income support and payment of insurance premiums, should be developed by division councils.

(b) The mandate of each institution designated as a hospital must be clearly identified to indicate the scope of medical services required.

4.8 **Each division council must define the core of services to be offered at each division hospital and develop a manpower plan to ensure that an appropriate complement of specialists and general practitioners is available to provide the mandated services in a continuous and ongoing way.**

(a) The core specialist team identified with the designated division hospital should include Canadian-certified specialists in such areas as radiology, pathology and anesthesiology, general internal medicine, general surgery and obstetrics and gynecology.

4.9 **In areas outside the major division centres, each division council must group hospitals within designated geographic areas into a single co-ordinated hospital services unit for purposes of ensuring partnerships for medical practice.**

(a) This grouping should foster the concept of 'one hospital on three or four sites'.

4.10 Provincial legislation must be modified to permit certain specialties which will be located only in base hospital centres to have "associate status" with division hospitals through formal agreements between division councils.

(a) The "associate status" specialists would visit division hospitals regularly for day surgery, less complex procedures and consultations.

(b) The "associate status" specialties could include ophthalmology, otolaryngology and orthopedics, among others.

4.11 The proposed Health Manpower Branch (Refer to Recommendation 5.24) of the Department of Health, in partnership with the Division Council Co-ordinating Board, the College of Physicians and Surgeons and the College of Medicine, must identify provincial manpower requirements - particularly in specialty areas - for the immediate and more distant futures and develop plans and policies for training and recruiting the required personnel so mandated acute care services can be provided without interruption.

(a) The plan must propose a system for the allocation of residency positions which reflects specialty requirements in the Saskatchewan setting and which minimizes the possibility of maldistribution.

(b) The plan for Saskatchewan must take into account levels of compensation, methods of compensation, opportunities to practise a specialty to the fullest degree, availability of technology and opportunities to break new ground.

4.12 For access to diagnostic and consultative capacities in larger health care institutions, rural division councils must establish sophisticated communication links between rural facilities and division hospitals, and arrange with the Regina and Saskatoon councils for such links between base hospitals and division hospitals.

(a) The Department of Health, in partnership with SaskTel, must develop a plan to link community hospitals with division hospitals, and division hospitals with base hospitals, and submit that plan to the division councils for their consideration and implementation.

4.13 Under the auspices of the Medical Care Insurance Branch, the physician services review panel must undertake a thorough analysis of the existing payment system and prepare revisions which encourage more professional practice of medicine and prompt consideration of different organizational structures for the delivery of medical services.

(a) The existing fee schedule should be revised in a major way to reflect the variations in a physician's time required for a particular service and the contribution of various types of medical experts relative to essential knowledge and skills.

(b) A capitation system should be developed to permit an annual payment rate to a group practice for a comprehensive set of services delivered to a complete cross-section of the population, based on the number of patients, their age-sex distribution, and the roles of associated professionals in that practice.

(c) Policies must be developed that would permit division councils to enter into contracts with physician groups which would provide a defined range of services for a stipulated sum of money.

(d) Exclusive of any incentives designed to attract physicians into particular settings, a salary plan must be developed which would permit division councils to employ physicians, on a basis that would be uniform across the province, for a defined range of medical services.

4.14 Regardless of the form of their compensation, physicians must continue to submit itemized reports of all activities to the Medical Care Insurance Branch of the Department of Health so medical activities can be measured and monitored on a province-wide basis.

(a) On the basis of its analysis, the Joint Medical Professional Review Committee should recommend to the Medical Care Insurance Branch the recovering of funds where inappropriate practices or services have been discovered.

4.15 The Medical Care Insurance Branch must develop processes to provide each division council with a complete report and analysis of volume, type and source of medical services delivered to the population of the division, including inter-divisional comparisons and provincial averages.

(a) Division councils should use this information to analyse the adequacy of division-based medical services and should develop plans to improve those services and educate the public in their use.

4.16 The mandate of the Joint Medical Professional Review Committee must be expanded to include the ability to develop and enforce payment regulations related to patterns of medical practice, which would include monitoring the number of procedures performed and the need for certain procedures.

(a) The medical practice protocol developed by the College of Physicians and Surgeons for the management of hospital utilization should be one of the bases for the analysis undertaken by the Joint Medical Professional Review Committee.

(b) Membership of the Joint Medical Professional Review Committee should be expanded to include two additional members appointed by the Division Council Co-ordinating Board.

4.17 The Government of Saskatchewan should enact legislation which would provide the College of Physicians and Surgeons with access to information systems in a physician's office for the purpose of an audit designed to ensure the highest quality of service is provided.

(a) The audits should be undertaken as part of a random sampling plan which is not motivated by punitive considerations.

4.18 Division councils should enter into contracts with a physician or physicians to provide general medical services for the residents of each supportive care centre operating under its jurisdiction.

(a) The contract could employ the capitation approach which identifies the range of services provided on behalf of a specified number of residents.

4.19 **The College of Medicine, in partnership with the Departments of Education and Health and the University of Saskatchewan, must develop a "mandate of the future" which clearly reflects its Saskatchewan setting, anticipated advances in technological and specialty services, and the interdependence and complementarity of roles among the five Colleges of Medicine in Saskatchewan, Alberta, British Columbia and Manitoba.**

(a) This "mandate of the future" should be developed by a five-member task force consisting of the Associate Deputy Minister of Education responsible for advanced education, the Associate Deputy Minister of Health responsible for professional services, the Vice-President of the University of Saskatchewan responsible for the health sciences, the Dean of Medicine and the Chairperson of the Division Council Co-ordinating Board.

(b) To provide a more adequate financial base which ensures that the College of Medicine can develop this mandate, its funding levels must be significantly upgraded.

(c) The new mandate should be developed in consultation with the deans of medicine in Alberta, Manitoba, and British Columbia.

(d) The "mandate of the future" should reflect the analysis, directions and recommendations in the report, *Towards a New Beginning*, by Dr. Kerr White.

4.20 **The College of Medicine should group the educational programs that make up its "mandate of the future" into four major categories - a basic undergraduate program, a core postgraduate training program, a priority one category and a priority two category - to reflect the most appropriate mandate of a medical training program in a Saskatchewan setting.**

(a) The core postgraduate program should consist of those specialty areas which set a high standard for achieving accreditation by the College of Medicine.

(b) The "priority one" category should consist of those specialty programs which reflect initiatives and developments founded on the historical contribution which the College of Medicine has made in the Saskatchewan and Canadian settings, as well as addressing the particular specialty requirements in this province.

(c) The "priority two" category should consist of those other highly specialized programs which personnel and financial resources permit to be undertaken and continued over a period of years.

4.21 **The University of Saskatchewan and the College of Medicine must ensure that, as a foundation for the medical training program, a strong basic sciences program exists which attracts a staff with a strong academic teaching and research orientation and which provides the base for the medical expertise required by today's graduates.**

(a) The University of Saskatchewan and the Government of Saskatchewan must give immediate consideration to developing a funding plan which would ensure that the appropriate and unencumbered infrastructure exists to facilitate research.

(b) To provide the basis for research activity to compare with other provinces and to utilize the extensive data which is available to assist in capturing matching grants from outside sources, the Department of Health must set a target of 1% of its total budget for health research activities.

(c) The College of Medicine must develop a strategy, in partnership with the Saskatchewan Health Research Board, for encouraging epidemiological research which would provide the basis for determining future health directions and initiatives.

4.22 **The College of Medicine must develop new future-oriented strategies for recruiting highly-qualified and respected candidates for the faculty of medicine at a time when those candidates can choose among many opportunities to apply their knowledge and the competition for their services has increased.**

(a) The funding formulas and policies must be reviewed and modified to ensure they provide incomes in keeping with those available in other medical colleges in Canada and take into account the income potential in private practice.

(b) The funding formula and the actual income earned by a full-time faculty member must recognize and emphasize the teaching and research roles and the clinical services that member provides.

(c) In accordance with the recommendations in the report, *Towards a New Beginning* by Dr. Kerr White, the University of Saskatchewan Board of Governors should create a **College of Medicine Board** and assign to it responsibilities necessary to achieve the purposes of the clinical services fund.

4.23 **In addition to the internship and residency opportunities provided at the base hospitals in Saskatoon and Regina, the councils of the other health services divisions must develop, with the College of Medicine, clearly defined training opportunities for graduates to gain medical practice experience in "model" rural settings.**

(a) The "training units" should be designated on the basis of the teaching capabilities and interests of the medical practitioners involved, the role models they can provide for graduates preparing to enter the practice of medicine, the breadth of experience interns and residents can gain in the particular setting, and the availability of resources from the College of Medicine.

(b) The division councils should enter into formal agreements with the College of Medicine to ensure a number of interns and residents are referred for their practical experience to these division training units.

4.24 **The College of Medicine must develop a pro-active program designed to attract students of native ancestry to enrol in the college each year.**

(a) The native/Indian institutes and colleges must co-operatively develop, in consultation with the College of Medicine, a special program for students of native ancestry who need to upgrade their academic standards to gain admission to the college each year.

(b) In partnership with the colleges, the Department of Education must develop incentives to encourage students to undertake the upgrading programs to enrol in the College of Medicine.

4.25 **The nursing profession of Saskatchewan, through its existing organizations and institutions, must immediately redefine its mandate to reflect the increased professional responsibility, knowledge and expertise associated with the practice of nursing in a setting characterized by sophisticated advances in the delivery of health care.**

(a) The nursing profession must commit itself to the newly-stated professional mandate and must strive to have it reflected in educational programs, employment practices, payment systems and in-service education.

(b) The mandate must define, in specific terms, what constitutes professional nursing practice compared to activities that might be performed by supportive staff under the direction of a nurse.

4.26 **Each division council, through a consultation process with the medical profession and other appropriate health care professional representatives, must develop a plan to ensure institutional and community-based services and practices provide nurses with the opportunities to fulfil an expanded professional role.**

(a) In a number of settings, especially in rural Saskatchewan, arrangements and opportunities must be provided for a registered nurse to become the primary care health professional.

(b) In examining the role of the nurse to make it more professional, opportunities should be provided for consultation with the ancillary professions.

4.27 **The category of PRIMARY CARE NURSE, requiring specialized training, must be created to be the first-contact health care professional in specified settings and circumstances.**

(a) The primary health care nurse designation should require the equivalent of one full academic term of post-BSN training, including general, medical and pharmaceutical aspects.

(b) Primary health care nurses should be designated as the professionals in charge of family health care centres wherever these are established, but most particularly in those institutions whose mandates have been redefined from acute care to family care.

(c) Primary care nurses should have a special responsibility for services in designated communities in Northern Saskatchewan and should require in their post-basic training a program component focusing on the special needs of northern communities.

4.28 **The community nurse designation must be expanded to include the broad scope of community-based services and amalgamate traditional public health nursing and home care nursing services.**

(a) Community nurses should be responsible for a range of programs which would include adult counselling clinics, home visits and assessments, school and pre-school services, immunization and screening, adult blood pressure testing and pre-natal and post-natal education.

4.29 Division councils, in consultation with the Saskatchewan Registered Nurses' Association and the Department of Health, must require the health care institutions within their jurisdictions to develop policies which ensure nurses have more opportunity than exists today to use their professional skills and knowledge to care for patients, and which minimize their non-nursing tasks.

(a) To ensure that nurses are provided with the opportunity to carry out their nursing responsibilies to the greatest degree possible, ward teams of people responsible for support services, including record-keeping, portering and housekeeping, must be in place, around-the-clock as necessary in the larger institutions.

(b) Division councils should develop policies which require hospitals and supportive care centres to ensure the appropriate ratios of certified nursing assistants to professional nurses.

(c) The Department of Health must alter the funding formula to reflect division councils' need for enough flexibility to require the institutions within their jurisdiction to develop appropriate mixes of professional and support staff that reflect the varying mandates and sizes of the institutions.

4.30 Carrying out the treatment regimen prescribed by physicians for each patient must become the primary responsibility of the nurses who are in charge of a ward in a larger hospital or who are responsible for a combination of wards in a smaller hospital.

(a) The nurse in charge must provide for the co-ordination of such care services as physical therapy, occupational therapy, diagnostic tests and pharmacy on a 24-hour basis, as required by each patient.

4.31 Provincially-negotiated contracts and division councils' policies must ensure institutions provide working conditions for nurses which reflect their professional role, with particular attention to innovative staffing approaches, hours of work, pay differentials for shifts, and proper orientation.

(a) Institutions should have the flexibility to develop staffing policies which permit flexibility in hours of work, to ensure shifts are the most effective length for the wards involved, and allow the use of primary care teams, job sharing, and improved rotation schedules drawn up wherever possible with input from the staff involved.

(b) Institutions should have the flexibility to increase the differentials paid to nurses who work shifts on evenings, nights, weekends and holidays to ensure they are reasonable and realistic.

(c) Staffing plans must ensure a proper orientation period for nurses new to a ward, varying in length according to the demands of the ward.

(d) Staff development and training opportunities should be made available to nurses on an ongoing basis.

(e) To facilitate proper staffing throughout a 24-hour period, division councils should develop plans for child-care centres which are located in particular institutions, or shared among them.

4.32 **Division councils must require base and division hospitals within their jurisdictions to redraft their bylaws to provide for a new internal body to be known as the HOSPITAL PROFESSIONAL ADVISORY COMMITTEE, to advise on such key topics as standards of practice, resource requirements of new program proposals, and quality of care.**

(a) Members of the hospital professional advisory committee should include senior clinical nursing representatives from all areas of the facility plus representatives of related non-medical, clinically-oriented professions such as pharmacy, physical therapy, occupational therapy and dietetics.

(b) The hospital professional advisory committee should be analagous to the medical advisory committee and report to the hospital management at the same level, and provision must be made for liaison between the two committees, which could include the exchange of minutes and reports.

4.33 **A NURSING EDUCATION COUNCIL must be established by the provincial government to develop and oversee the application of a co-ordinated and integrated approach to nursing education which will result in an ongoing articulation of the programs offered by the University of Saskatchewan and the Saskatchewan Institute of Applied Science and Technology.**

(a) Membership of the Nursing Education Council should include representatives of the Saskatchewan Registered Nurses' Association, the Saskatchewan Institute of Applied Science and Technology, the University of Saskatchewan, the University of Regina, and the Departments of Health and Education.

(b) The goal of the articulation of the nursing programs must be to permit nursing students to progress smoothly from the Saskatchewan Institute of Applied Science and Technology to the University of Saskatchewan without any kind of obstacles or loss of credits or time.

(c) The Nursing Education Council must develop a strategy to ensure a more comprehensive and extensive program of practicums for nursing students to ensure first-hand experience in institutional and community settings, with a special emphasis on providing opportunities in rural and Northern Saskatchewan.

4.34 **The Nursing Education Council, in partnership with the Departments of Health and Education, must establish as a long-term target a steady increase in the percentage of Saskatchewan nurses who acquire a Bachelor of Science in Nursing degree as the basic requirement for the practice of nursing, and develop a strategy to achieve it.**

(a) The plan should identify the financial and personnel resources required to achieve this goal, and establish the appropriate incentives to ensure that 20% of Saskatchewan Institute of Applied Science and Technology graduates will continue their training at the College of Nursing by 1992, rising to 40% over a period of 10 years.

4.35 **To address the nursing shortage which is anticipated for Saskatchewan and to ensure the province's need for nurses is met, the Department of Education must immediately increase by 50 the number of training places in the diploma nursing program at the Saskatchewan Institute of Applied Science and Technology, and provide the funding for such an increase.**

(a) The Nursing Education Council should examine the possible need for a further increase in enrolment in the program.

4.36 **The Nursing Education Council must develop a comprehensive program to increase the opportunities for nurses to specialize in their chosen fields, once they have achieved the bachelor's degree, to meet the growing demands of health care specialization and technological development.**

(a) Opportunities should be available at three levels of training and specialization:

(i) One academic term of post-BSN training or an approved internship program leading to an advanced nursing certificate, for those areas in which the focus is on only one specialty and some additional knowledge is required beyond the basic program, such as psychogeriatrics, orthopedics or long-term care.

(ii) A full university year of post-BSN training leading to a specialist certificate, for more complex areas such as psychiatry or critical care, and to train primary care nurses.

(iii) A full program leading to a masters of science in nursing, which permits more complex specialization.

(b) The global funding provided to the University of Saskatchewan by the Department of Education must recognize the extra demand on the College of Nursing to increase the number of nurses graduating with a bachelor's degree.

4.37 **In consultation with the Nursing Education Council, division councils must develop plans which will identify opportunities for and encourage students to do the practical periods of training that are part of the nursing program in community settings and hospitals throughout the province.**

4.38 **A psychiatric nursing training program must continue to be offered under the auspices of the Saskatchewan Institute of Applied Science and Technology to ensure that an adequate number of graduates is available to serve the people with mental illnesses in Saskatchewan.**

(a) The first year of the program must continue to be offered in common with those students registered in the RN and CNA programs.

(b) The number of training spaces for students entering the psychiatric program each year should be maintained at 110 to 120.

4.39 **The Wascana and Kelsey campuses of the Saskatchewan Institute of Applied Science and Technology must have a uniform policy of providing the opportunity for graduates from the psychiatric nursing program to pursue studies for an RN qualification if they choose to do so.**

(a) The requirements for entry to the RN qualification program from the Wascana and Kelsey programs should be identical, and should amount to one year of additional training.

4.40 **Formal arrangements must be developed by the Departments of Education and Health with the University of Brandon in Manitoba and Douglas College in British Columbia to provide enhanced opportunities for registered psychiatric nurses to obtain bachelor's degrees with a specialization in psychiatric nursing.**

(a) The formal arrangements with the two institutions must provide for both on-campus and long distance education components leading to graduation.

(b) The arrangements should result in 20% to 25% of all psychiatric nurses having a bachelor's degree in 10 years.

4.41 **The Department of Health must ensure policies and procedures of Saskatchewan optometrists adhere to the principle that a prescription for eyewear is the property of the patient and must be given to the patient when an examination is completed.**

(a) The Saskatchewan Association of Optometrists must continue its efforts to inform its members of their responsibility to adhere to this principle.

(b) The Optometry Act should be amended to include a provision which requires a practising optometrist to present a prescription to a patient without any conditions.

4.42 **The Saskatchewan Pharmaceutical Association and the College of Pharmacy, University of Saskatchewan, must develop new strategies to enable pharmacists to use their professional knowledge and skills to determine medical protocols for individual patients and provide support and interpretive counselling to them.**

(a) To ensure the professional role of pharmacists is enhanced, the College of Physicians and Surgeons and the Saskatchewan Pharmaceutical Association should undertake to review or determine how the roles of physicians and pharmacists could be more complementary.

4.43 **The Department of Health should adopt a policy of insuring a specified number of chiropractic services for a person during a year, with the individual assuming responsibility for part of the cost of any additional services used during the same year.**

(a) The first 12 chiropractic services each year should be completely paid for by the Department of Health, and 50% of the cost of any additional services should be paid for by the individual.

4.44 **Chiropractors holding a valid membership in the Chiropractors Association of Saskatchewan should have the right to apply for courtesy privileges within a neighboring hospital which would enable them to order X-rays for skeletal examinations.**

4.45 **Since residents of supportive care centres may not have a dentist or be able to visit a dentist, each division council should contract with dentists working in communities which have supportive care centres for the provision of basic dental services in those centres.**

4.46 **Therapy services throughout the province should be combined into therapy program units consisting of physical, occupational, and speech and language components, established by division councils and staffed by a team of professional and supportive staff employed by the councils.**

(a) The therapy teams should be responsible for all therapy services wherever they have to be delivered; i.e. community settings, institutions, family health care centres, rehabilitation facilities and the homes of patients, and on a regular outreach basis to outlying facilities and family health care centres.

(b) In larger institutions such as base hospitals, therapy services should be provided by resident therapists.

(c) Independent of the division council teams, therapists may also be associated with physicians and other health care professionals in medical services centres.

(d) Appropriate targets for ratios of such therapists to the population served might be:

(i) one physical therapist per 4,000 population
(ii) one occupational therapist per 10,000 population
(iii) one speech and language pathologist per 20,000 population

4.47 **The University of Saskatchewan should create a new School of Rehabilitation Sciences which includes the present School of Physical Therapy and a new program of occupational therapy.**

(a) The two programs should share a common core of subjects before students specialize.

(b) Provincial funding should continue to provide adequate resources for the School of Rehabilitation Services to maintain the present intake of 30 students to the physical therapy program.

(c) The occupational therapy program should graduate 18 students a year.

4.48 **The Government of Saskatchewan should enter into contracts with people who want to train as speech and language pathologists and audiologists at universities outside Saskatchewan, offering bursaries with a built-in commitment to return to the province to practise, plus other incentives.**

(a) As an encouragement to graduates to return to practise in Saskatchewan, the contracts should provide guaranteed employment.

4.49 **The Government of Saskatchewan should pass a special act of the legislature to give speech and language pathologists and audiologists professional status and regulate the professions.**

4.50 **Each division council must employ dietitians/nutritionists within its institutions and as part of its community-based health services team, to provide services such as educational programming for groups, individual counselling, advising institutions on their food services, and working with patients referred by physicians.**

(a) The nutritionists/dietitians should provide outreach services to outlying facilities and locations.

(b) Dietitians/nutritionists should be employed by division councils in numbers that take into account the total population of the division, the percentage of seniors and the number of institutional beds, with a suggested ratio of one per 5,500 people.

(c) Division councils should work with the University of Saskatchewan to provide enough dietetic internship positions to handle the entire graduating class of the program.

4.51 Each division council must offer a chiropody service provided by a team of chiropodists and chiropody assistants in conveniently-located clinics throughout the division.

(a) The appropriate ratio of chiropodists might be one per 50,000 population.

4.52 A central division ambulance services unit which can provide the most sophisticated lifesaving support systems must be staffed by personnel with various levels of training, including the basic emergency medical technicians (EMTs), advanced emergency medical technicians (EMT-As) and paramedics (EMT-Ps).

(a) The suggested complement of core staff for the division unit headquarters is eight EMTs, two EMT-As and one EMT-P per 50,000 population.

(b) In addition to the emergency services they provide, paramedics should perform supervisory, training and support functions for the division medical transportation system.

(c) The Department of Health and division councils must give special attention to the salaries and working conditions of emergency medical personnel to enable Saskatchewan to successfully compete with other provinces in their recruitment and retention.

4.53 Long-term agreements for the training of respiratory therapists must be formalized between the Saskatchewan Department of Education and the Southern Alberta Institute of Technology in Calgary and the Northern Alberta Institute of Technology in Edmonton for the training of five students a year in each institute.

(a) The agreement negotiated should call for the first year of training to be at the institutes, and the practical component of the second year at an appropriate Saskatchewan hospital selected by the student before enrolling, and arranged with the hospital.

4.54 Division councils must provide the basis for health care institutions to establish policies, in accordance with provincially-defined standards, which determine the nursing services staff mix on each ward and which suggest particularly the ratio of certified nursing assistants to professional nurses.

(a) Policies of hospitals and supportive care centres should clearly define the scope of responsibility of certified nursing assistants in relation to registered nurses.

4.55 The Department of Health, in co-operation with the Department of Education, must establish a one-year rehabilitation therapy program to train CERTIFIED THERAPY ASSISTANTS who would work as members of the division therapy team under the direction of physical and occupational therapists.

(a) Government regulations should be developed to provide for certification of therapy assistants.

(b) The certified therapy assistants would deliver the 'outreach' services in homes, family health care centres and supportive care centres in communities throughout the province.

4.56 A HEALTH SCIENCES SCHOOL FOR CONTINUING EDUCATION must be established which would actively involve each of the health science faculties at the University of Saskatchewan and the Saskatchewan Institute of Applied Science and Technology in developing a sophisticated, comprehensive and co-ordinated distance education program focusing on in-service training as well as credit courses.

(a) The School for Continuing Education should be administered by a board consisting of the deans of the University of Saskatchewan Colleges of Medicine, Nursing, Pharmacy and Dentistry, and the deans of the health sciences and community services divisions of the Saskatchewan Institute of Applied Science and Technology.

(b) The School for Continuing Education must develop a communications network which taps the potential of such means as fibre optics, satellite systems and cellular communications.

4.57 The budget of the Health Sciences School for Continuing Education should be established on the basis of contributions by the sponsoring training institutions, grants from the major Saskatchewan health professional associations and the Department of Education, as well as enrolment fees.

5. Provincial Programs in a New System

5.1 **The Children's Dental Program should continue to be offered under the private dental practice model for children aged 5 to 13.**

5.2 **Initiatives being taken by the Department of Health to provide services to children living in core areas of the major cities should be continued, and expanded as needs indicate.**

5.3 **To improve their accessibility to school-age children, dentists should extend their office hours to a greater extent.**

5.4 **The Saskatchewan Formulary system should continue with renewed vigor its excellent efforts to provide quality, effective and cost-efficient products and a list of interchangeable products for use by Saskatchewan residents.**

(a) The price tendering policy should be continued for all interchangeable brands. In addition, the province should negotiate prices for higher volume single supplier drugs to take advantage of volume and package size.

(b) The purchase price of the product should be listed in the Formulary.

5.5 **The Department of Health should establish a PHARMACEUTICAL PRACTICES BOARD OF SASKATCHEWAN, which would assume the combined responsibilities, roles and mandates of the Saskatchewan Formulary Committee, the Joint Committee on Drug Utilization and the Minister's Advisory Committee on the Safe Use of Drugs.**

(a) The Pharmaceutical Practices Board should consist of one representative from each of the College of Medicine and College of Pharmacy, University of Saskatchewan; the Saskatchewan Medical Association; the College of Physicians and Surgeons; the Saskatchewan Pharmaceutical Association; the Saskatchewan Registered Nurses' Association; the Saskatchewan Home Care Association; the Saskatchewan Seniors Association; the Consumers' Association of Canada, Saskatchewan Branch; and the Department of Health.

(b) Specific responsibilities of the board should be:

(i) to use Saskatchewan's extensive drug utilization data bank for research into the appropriate use of prescription drugs. In consultation with medical and pharmacy professionals, it should recommend specific actions to ensure more appropriate use of prescription drugs.

(ii) to identify prescribing and dispensing problems and work with the medical and pharmacy regulatory bodies to use education and regulatory measures to deal with them.

(iii) to recommend public education programs about the benefits and risks of prescription drugs to help people make informed choices.

(iv) to ensure the commitment of research money made during the enactment of federal Bill C-22 is fulfilled.

(c) The drug quality assessment committee should function as a subsidiary of the Pharmaceutical Practices Board.

5.6 **The Pharmaceutical Practices Board of Saskatchewan should determine specific criteria to govern the circumstances in which it is appropriate to write a "no substitution" prescription, and a procedure to monitor the frequency with which these are written.**

(a) The board should have the power to require physicians who frequently use this option to provide the scientific evidence or rationale for doing so.

5.7 **The Department of Health should develop an agreement with the Poison Control and Drug Information Service operated by Foothills Hospital in Calgary, Alberta which would provide a high-quality, sophisticated program to serve the needs of all Saskatchewan health care professionals, institutions and residents.**

(a) The resources allocated to the existing poison control centres at Regina General Hospital and University Hospital should be directed toward the cost of subscribing to this poison control service.

(b) Toll-free numbers for the centre should be widely advertised to health care givers and the public, to provide access 24 hours a day.

(c) Foothills Hospital Poison Control Centre should provide all necessary follow-up services to callers, and consultative, educational and training services to Saskatchewan clinicians and health personnel.

5.8 **The Department of Health must develop a provincial system of laboratory services which defines the scope of services to be provided in various settings and levels throughout the province and which reflects the health services division structure.**

(a) Three categories of laboratory services should be established:

  (i) Category 1 should identify base hospital laboratories as the focus for the provision of special services, with the "Centres of Excellence" concept being the mechanism of choice.

  (ii) Category 2 should identify the range of services available at division hospitals and an identified number of services which would be more appropriately delivered at that level should be transferred from the base hospitals and the Provincial Laboratory.

  (iii) Category 3 should identify the services which would be available in community hospitals, generally involving routine and basic tests.

(b) The role of the Provincial Laboratory must be reviewed and its mandate redefined to complement and supplement the roles of hospital-based laboratories.

(c) Sophisticated communications technology should link all laboratories to facilitate a more comprehensive and responsive service at all levels.

5.9 **A LABORATORY SERVICES REVIEW BOARD should be established by the Minister of Health to license medical laboratories; set, monitor and control standards; provide consultation and advice to laboratories; and co-ordinate services.**

(a) The board should be comprised of representation from the Saskatchewan Health Care Association, Saskatchewan Society of Medical Laboratory Technologists, College of Physicians and Surgeons, Saskatchewan Medical Association, Department of Health, and the public at large.

5.10 The methodology and usefulness of laboratory services done by physicians in their offices, and those performed on a referral basis, must be reviewed by the Laboratory Services Review Board, and examined with a view to introducing quality control and reimbursement on a cost basis only.

5.11 In order to inject accountability and monitoring into the laboratory system, all laboratories in the province must regularly provide the Laboratory Services Review Board with physician profiles as to lab ordering patterns and utilization of such services.

5.12 Methods should be established to require most services provided by private laboratories to become the responsibility of hospital-based laboratories, and no new private laboratories should be licensed until a final plan is adopted.

5.13 The Saskatchewan Cancer Foundation should maintain its current autonomous operating status and its reporting relationship with the provincial government, as legislated by The Saskatchewan Cancer Foundation Act.

5.14 The name of the Saskatchewan Cancer Foundation should be changed to the SASKATCHEWAN CANCER TREATMENT AND RESEARCH FOUNDATION to more accurately reflect its mandate and function.

5.15 The Saskatchewan Cancer Treatment and Research Foundation should be governed by a 10-member board appointed by the Lieutenant-Governor, with seven representatives nominated by the Division Council Co-ordinating Board and one representative nominated by each of the College of Medicine, the College of Physicians and Surgeons and the Saskatchewan Registered Nurses' Association.

(a) Board members should be appointed for three-year terms, and be eligible for reappointment for a second term.

(b) The chairperson should be appointed by the board from among its members for one-year terms.

5.16 In Regina and Saskatoon, joint planning committees consisting of administrative and medical representatives from the Allan Blair Memorial Clinic and the three Regina hospitals, and the Saskatoon Cancer Clinic and the three Saskatoon hospitals, respectively, should be established to facilitate the joint planning and co-ordination of cancer clinic operations.

5.17 The Saskatchewan Cancer Treatment and Research Foundation should expand its chemotherapy services to division hospitals, provided appropriate personnel and facilities are available, to enable cancer patients in rural Saskatchewan to obtain chemotherapy treatments nearer to home.

5.18 The Saskatchewan Cancer Treatment and Research Foundation must maintain its strong commitment to the highest quality of cancer treatment and must, as required, constantly monitor and enhance the quality control of treatment, as well as the registration and follow-up of cancer patients.

5.19 **The status of the Saskatchewan Alcohol and Drug Abuse Commission should be clarified and confirmed through modifications to The Saskatchewan Alcohol and Drug Abuse Commission Act which ensure a greater degree of independence in the management and operation of its programs, and its name should be changed to the SASKATCHEWAN ALCOHOL AND DRUG ABUSE FOUNDATION to reflect this re-affirmed autonomy and new operating status.**

5.20 **The Saskatchewan Alcohol and Drug Abuse Foundation should be governed by a 14-member board appointed by the Lieutenant-Governor, with seven members nominated by the Division Council Co-ordinating Board, at least one of whom represents the northern division councils; two representatives nominated by Alcoholics Anonymous organizations; and one representative nominated by each of the Saskatchewan Teachers' Federation, the College of Physicians and Surgeons, the Saskatchewan Mental Health Association, the Saskatchewan Pharmaceutical Association and P.R.I.D.E.**

(a) Board members should be appointed for three-year terms, with eligibility for reappointment for a second term.

(b) The chairperson should be appointed by the board from among its members for one-year terms.

5.21 **The regional boundaries for the delivery of alcohol and drug abuse services should be changed to correspond to those established for the health services divisions.**

5.22 **Employees of the Saskatchewan Alcohol and Drug Abuse Commission should become employees of the Foundation and their employment should be independent of the provisions of The Public Service Act and regulations.**

(a) The transfer of Commission employees to the Foundation should occur without loss of employment benefits.

5.23 **An ALCOHOL AND DRUG ABUSE COMMITTEE should be established in each health services division to maximize community input into program planning and to facilitate integration of alcohol and drug abuse services with division programs.**

(a) The committee should include a representative of the Saskatchewan Alcohol and Drug Abuse Foundation, representatives of professional and advocacy groups and citizens at large.

(b) The committee should be appointed by the division council in consultation with local, professional and advocacy groups.

(c) Reporting to a designated division councillor, the committee should provide input and advice on program planning based on community needs.

(d) Based on input from the advisory committee, the division council should liaise with the Saskatchewan Alcohol and Drug Abuse Foundation on matters relating to alcohol and drug abuse services and needs at the community level.

5.24 The Department of Health should create a HEALTH MANPOWER BRANCH which would work closely with division councils, health care professionals and other health care providers in developing and maintaining a manpower plan which ensures an adequate supply and distribution of health and medical professionals in the province.

(a) The Branch should develop, monitor and maintain an up-to-date comprehensive inventory of health manpower.

(b) The Branch should develop sophisticated manpower forecasts and initiate strategies to deal with projected shortfalls or surpluses.

(c) The Branch should consult with the Department of Education and individual training institutions regarding education and training programs, curriculum, clinical practicums and continuing education, and submit its plans for education bursaries, program modifications and expansions, with requests for changes, to the Deputy Ministers of Health and Education.

(d) The Branch should advise the Minister of Health on collective bargaining issues that affect manpower planning, and on legislation and regulatory issues related to health professions.

5.25 Bursary and other education assistance programs sponsored by the Department of Health should be pro-active in providing ongoing contact with and support to bursary recipients during their training, contributing to interest in employment and practice opportunities in the Saskatchewan health care system.

5.26 Monitoring and communication systems should be developed jointly by the Health Manpower Branch, Department of Health and the various educational institutions to facilitate ongoing contact with graduates of Saskatchewan health care programs.

(a) Such mechanisms should be oriented to informing graduates of employment and practice opportunities in Saskatchewan and generally to maintaining links between graduates and the health care system in the province.

5.27 A SOCIAL POLICY SECRETARIAT should be established with representation from the Departments of Health, Social Services, Education, Human Resources, Labor and Employment, the Saskatchewan Alcohol and Drug Abuse Foundation, the Saskatchewan Housing Corporation and the Saskatchewan Family Foundation, to facilitate communication, co-ordination and planning of common programs and services.

(a) Secretariat members should be senior department officials appointed by their respective deputy ministers.

(b) The Secretariat should review and make recommendations to the deputy ministers of the social policy departments on issues, policies and priorities of common interest, including staffing and financing requirements, program components and standards, and funding of non-government organizations (NGOs). (Refer to Recommendation 5.31).

(c) The Secretariat should report annually to the Planning and Priorities Committee of Cabinet.

(d) The Secretariat should establish a method of communicating with the Division Council Co-ordinating Board, to advise, share information, and consult on matters which affect services provided by division councils.

5.28 Overall responsibility for respite and community-based residential programs for special needs groups, now administered by the Departments of Health and Social Services, should be concentrated in the Department of Health, and responsibility for local management and delivery of these programs transferred to the division councils.

(a) The Department of Health should have responsibility for licensing of and estabishing provincial operating standards and basic funding criteria for group homes.

(b) On the basis of assessed community needs, division councils should provide respite and other supportive living services through their home care programs, and fund group homes to assist individuals with special needs to remain in the community.

(c) The Department of Social Services should continue to provide counselling and other social programs required by special needs families or individuals living in the community.

(d) Subsidized housing which provides minimal or no supervised or supportive living services should continue to be the responsibility of the Saskatchewan Housing Corporation.

5.29 Specialized care institutions which offer programs and services beyond the mandates of supportive care centres and hospitals and which serve the total population must be operated directly by the Government of Saskatchewan.

(a) Such institutions should include the Wascana Rehabilitation Centre, Parkridge Centre, Saskatchewan Hospital North Battleford and the Valley View Centre.

(b) Each of these institutions should have a management board of eight to 10 people appointed by the Lieutenant-Governor, including at least two nominees of the Division Council Co-ordinating Board.

5.30 In order to provide a continuity in the supportive living services offered within institutions and in the community, and to facilitate a continuum of care, responsibility for the Valley View Centre should be transferred to the Department of Health from the Department of Social Services.

(a) Social work and other support programs and services offered for the mentally handicapped through the existing Community Living Program of the Department of Social Services should continue to be the responsibility of that department.

5.31 A major function of the proposed Social Policy Secretariat should be to facilitate co-ordination, consistency and accountability in provincial funding of non-government organizations in the social policy sector.

(a) Specific objectives and responsibilities relating to non-government organizations should include:
  - Development of a process which establishes provincial funding criteria, and a monitoring and evaluation system.
  - Determination of the annual distribution of funds to provincial-level NGOs funded by more than one government department.
  - Facilitation of co-operation and co-ordination between NGOs and government departments.
  - Consultation and guidance to NGOs about efficiencies and proposals about sharing of administrative functions.

5.32 **Division councils should be responsible for funding local health-related non-government organizations in their divisions, and funding decisions should be in accordance with provincial criteria established by the Social Policy Secretariat.**

5.33 **Each government department in the social policy sector should designate a single official or unit as the primary contact for non-government organizations to facilitate assistance to and communication with them.**

(a) This single official or unit should also serve as the primary contact for division councils on matters relating to local-level NGOs.

5.34 **The Government of Saskatchewan should establish an autonomous HEALTH ANALYSIS AND DEVELOPMENT COMMISSION under a special act of the legislature to monitor and analyse health programs and practices, determine their effectiveness and efficiency, and recommend policies to the government and division councils.**

(a) The Commission should study health delivery systems in other jurisdictions, analyse program delivery systems, and comment on the effectiveness and appropriateness of initiatives in the health services divisions.

5.35 **The Health Analysis and Development Commission should consist of 10 members and a chairperson all selected by a special committee and appointed by the Lieutenant-Governor.**

(a) An eight-member selection committee should be appointed, with the Chief Justice of the Province of Saskatchewan as chairperson, and made up of the Presidents of the Universities of Saskatchewan and Regina, the Saskatchewan Federation of Labor, the Saskatchewan Chamber of Commerce, the Saskatchewan Association of Rural Municipalities, the Saskatchewan Urban Municipalities Association and the Consumers' Association of Canada, Saskatchewan Branch.

(b) The selection committee should submit the list of 10 members and the chairperson to the Lieutenant-Governor who would officially appoint the Commission.

(c) Members should be appointed for three-year terms on a rotating basis, with one-third of the membership appointed each year.

(d) The chairperson should be appointed for a three-year term.

(e) Members should be permitted to be re-appointed for two terms.

5.36 **The Health Analysis and Development Commission should be responsible to the Saskatchewan legislature, and should present to the Legislative Assembly a formal annual report commenting on the health care system in the province.**

(a) The purpose of the report should be to indicate the status of health care services, the outcomes which were achieved, potential dangers or crises which may develop, and overall directions for the future.

5.37 **To carry out its mandate to the fullest degree, the Health Analysis and Development Commission must establish a Health Analysis and Development Centre which would study issues such as quality assurance, health care utilization, cost effectiveness and technology assessment.**

(a) Specifically, the Commission must monitor, assess and report on the performance of the health system with the following focus:

(i) the effective use of human and financial resources.

(ii) the effectiveness of the delivery systems for the Saskatchewan setting.

(iii) the unmet health care needs of various groups in society.

(iv) the degree to which decisions and policies result in identifiable outcomes.

(b) Specific research in these and other areas would be undertaken on initiatives from within the Commission or on the request of division councils, the Division Council Co-ordinating Board or the Department of Health, with the Commission itself determining the priorities of such research.

(c) The Commission would be expected to be knowledgeable concerning similar projects occurring in Canada, as well as other countries, and must promote the sharing of such studies and information.

(d) The Government of Saskatchewan must make a commitment to establish a budget which will permit the appointment of a nucleus of staff with research, administrative and support skills to ensure the Commission's mandate is fulfilled and a continuity of service is maintained.

(e) Consideration should be given to locating the Centre near Innovation Place on the University of Saskatchewan campus.

5.38 **The Health Analysis and Development Commission must establish a formal liaison with the Division Council Co-ordinating Board and the Department of Health so it can share its research and information about the delivery of health care services throughout the province and in various divisions.**

(a) The Commission should meet at least annually with the Division Council Co-ordinating Board and the Department of Health to discuss health care issues and concerns identified by council and department representatives and to report on studies concluded by the Centre.

5.39 The Saskatchewan Department of Health should join with the Departments of Health in Manitoba and Alberta to establish a PRAIRIE HEALTH CARE ETHICS CENTRE for the purposes of research, study, analysis, proposing policies, developing information and educating the public in the field of ethics.

(a) The Prairie Health Care Ethics Centre should be funded by the three provinces equally to ensure it has the revenues necessary to carry out its mandate.

(b) It should be a resource for ethics forums and committees in the three provinces, providing literature and speakers to professional and hospital ethics committees and the general public, gathering and disseminating information and research in the ethics field, and generally working to increase people's sensitivity in this area.

(c) It should examine such subjects as cost-quality tradeoffs, durable powers of attorney, and living wills.

5.40 A PROVINCIAL FORUM ON HEALTH CARE ETHICS should be established in Saskatchewan to develop provincial principles and guidelines on health care issues, to provide the opportunity for discussion, and to serve in an advisory capacity to government and local authorities.

(a) The forum should include representatives from the following groups: university faculties of medicine, base (teaching) hospitals, professional physician and nursing bodies, law schools, university philosophy departments, and the religious community.

5.41 Each division council must establish a HEALTH CARE ETHICS ADVISORY COMMITTEE to develop strategies for interpreting and implementing provincial guidelines in this field, and to identify and advise on issues of particular significance to the division.

(a) The health care ethics advisory committee should include representatives of physicians, nurses, the religious community, workers in community-based programs, and members of the public.

(b) It should act as a resource for hospitals, supportive care centres and community-based programs.

(c) Individual ethics committees must be established at base hospitals and should have as their core members representatives of the medical, nursing and social work professions, ethicists and members of the religious community.

6. Better Health for Northern Residents

6.1 **Northern Saskatchewan should be divided into three distinct HEALTH SERVICES DIVISIONS for the purpose of organizing health care services and managing their delivery.**

(a) The health care divisions may be defined as follows:

(i) Churchill River West Division, which would include La Loche, Buffalo Narrows, Ile-à-la-Crosse, Beauval and Pinehouse Lake.

(ii) Athabasca Basin-Wollaston Lake Division, which would include Uranium City, Fond-du-Lac, Stony Rapids, Black Lake and Wollaston Lake.

(iii) La Ronge Division which would include La Ronge, Southend, Sandy Bay, Pelican Narrows, Creighton and Cumberland House.

6.2 **An authority known as the HEALTH SERVICES DIVISION COUNCIL should be established in each northern division to administer health care services which fall under its mandate as designated by the provincial government.**

(a) The council should consist of representatives appointed by local elected municipal authorities and Indian bands in the area. Senior officials from the Northern Health Services Branch (Department of Health) and one senior official of the Medical Services Branch (Health and Welfare Canada) should serve as ex-officio members.

(b) Councillors should be appointed for three-year terms, eligible for reappointment for a second term, with a chairperson selected from among the council membership for a one-year term.

(c) Standing committees, chaired by councillors and reporting directly to the council, should be appointed to monitor the categories of health service delivery: acute care services, long-term care services, mental health services, community-based services (public health and home care), alcohol and drug abuse services, and management and finance.

6.3 **The northern division councils should have authority and responsibility for all aspects of health service, including program planning, evaluation, budget management, and delivery of acute care, ambulance services, long-term care, community-based services, home care, mental health, and alcohol and drug abuse treatment.**

(a) Division councils should be accountable to the municipal authorities and Indian bands they represent for the comprehensiveness, availability and quality of health services, and to the Department of Health for the effective and appropriate use of financial resources.

(b) Division councils should employ the management and professional staff necessary to administer and deliver programs and services.

(c) Division councils should be directly responsible for institutional services and should either own the facilities or contract their services from private owners such as the Catholic Health Council.

6.4 **The Northern Health Services Branch should continue to function as a separate branch of the Department of Health, responsible for funding and monitoring the standards, comprehensiveness, quality and accessibility of all health services provided by the northern divisions.**

(a) The headquarters for the Branch should be in La Ronge.

(b) The Branch should ensure funds made available to the councils provide the basic core services required and reflect government priorities and policies.

6.5 **All functions of the Department of Health for acute care, ambulance services, long-term care, mental health, and community-based services (including home care and public health) in the North - which are currently managed by several branches - should be delegated to the Northern Health Services Branch.**

6.6 **The Northern Health Services Branch should work closely with the division councils and provide consulting and support services to them.**

(a) The Branch's executive director and medical health officer should serve as ex-officio members on the councils.

(b) The Branch should give management support to the divisions by providing administrative backup as required and assistance in the development of operational and management systems training for council members and senior management.

6.7 **The Northern Health Services Branch should have a special responsibility, in partnership with the northern division councils, for recruiting and training professional health care staff.**

(a) Community-based professional staff should be recruited and employed by the Branch, and contracted to the division councils.

(b) The Branch should assist division councils in recruiting professional staff for facilities.

(c) The Branch should provide support and direction to professional staff within the divisions to ensure up-to-date and high-quality health care services.

(d) The Branch and division councils should have joint responsibility for the orientation of new staff and for in-service training, professional development and regular staff conferences.

6.8 **The Northern Health Services Branch should create a financial management unit within its organization to assist northern division councils in all matters related to financial management.**

(a) The responsibilities of such a unit should include budget planning and forecasting, expenditure monitoring and control, auditing and the development of financial systems.

6.9 **A classification system of northern health care facilities should be**

established in order to provide a complete range of quality services comparable to those available in southern facilities.

(a) A division hospital should be located in each northern division, providing a wide range of health care services.

(b) Family health care centres, regularly visited by an array of health care professionals, should be situated in several northern communities.

(c) Satellite outreach clinics should be established in small communities, providing basic health care treatment and public health services.

6.10 **The facility designated as the DIVISION HOSPITAL in each of the three divisions should be a multipurpose facility ranging in size from 15 to 30 acute care beds (depending on the population served) providing primary and secondary care, as well as other services which might include long-term care, rehabilitation, geriatric care, mental health, alcohol and drug abuse, outpatient and ambulance services.**

(a) Division hospitals should be established in each division as follows:
- La Ronge Division - La Ronge (acute care, long-term care, mental health, alcohol and drug abuse treatment)
- Churchill River West Division - Buffalo Narrows (acute care)
- Athabasca Basin-Wollaston Lake Division - Stony Rapids (acute care, long-term care)

(b) Criteria for determining the services, technology and equipment to be available at each division hospital must recognize the unique needs and circumstances of the north, and may result in facilities exceeding those found in communities of similar size in southern Saskatchewan.

(c) Family health care centres and satellite outreach clinics should serve as extensions of the division hospital in their divisions. They should direct patients to the division hospital for more specialized diagnosis and treatment.

(d) Each division hospital should operate a health information telephone service which functions as a crisis hotline and health services information centre.

(e) A sophisticated medical communications system should be developed to allow the division hospital to consult with other facilities in the division and with major facilities outside the North.

6.11 **FAMILY HEALTH CARE CENTRES should be established in smaller northern communities in each division, to provide basic health care services, primary care and community-based services on a regular basis.**

(a) Division councils should determine the locations of the family health care centres on the basis of existing nursing stations, community need and geographic location.

(b) Each family health care centre should be staffed permanently by no less than three primary care nurses. These nurses and the physicians within the division should function interdependently.

(c) The professional teams visiting the centres should include a wide range of medical and health professionals such as general practitioners, obstetricians, physical and occupational therapists, nutritionists, psychologists, mental health nurses, audiologists, speech and language pathologists and chiropodists.

6.12 **To complement the services provided at the division hospital, the facilities at Ile-à-la-Crosse and La Loche should be designated as comprehensive family health care centres and should offer primary inpatient acute care, as well as expanded alcohol and drug abuse treatment and rehabilitation, long-term care and mental health services.**

(a) The centre at Ile-à-la-Crosse should include a major alcohol and drug abuse treatment and rehabilitation program for the division, as well as beds designated for primary acute care, long-term care, and mental health, to serve Ile-à-la-Crosse and neighboring communities.

(b) The centre at La Loche should provide primary acute care, alcohol and drug abuse treatment, mental health, and long-term care inpatient beds, primarily directed at fulfilling the needs of its surrounding community.

6.13 **All major renovations or new construction of division hospitals and family health care centres in the North should include training facilities for staff and students.**

6.14 **SATELLITE OUTREACH CLINICS should be established in smaller northern communities where no other formal health services exist, to provide public health, health promotion, basic treatment and emergency services.**

(a) The clinics should be staffed by full-time community health workers and assistants under the supervision of a primary care nurse at the nearest family health care centre.

(b) Professional services should be provided through regularly scheduled visits by health professionals, as determined by the division councils.

6.15 **Each northern division council should establish a network of funded personal care homes in communities having family health care centres to accommodate Level III and IV residents from surrounding communities.**

(a) Each personal care home should accommodate four to five residents, and a resident charge equal to that established in supportive care centres should apply.

(b) The personal care homes should be staffed by resident managers, with medical and health care support provided on an outreach basis from the family health care centre.

6.16 **The many components of community-based services should be drawn together into a total package within each northern division, and a completely multi-disciplinary team approach taken in the provision of such services.**

(a) The package should include mental health counselling and support services, public health nursing for children and adults, public health inspection, alcohol and drug abuse counselling and support services, home care/supportive living services, rehabilitation, speech and language pathology, nutrition, dental care and chiropody.

(b) The division community health services team should include public health nurses, public health inspectors, mental health nurses, community health workers, community health assistants, physical and occupational therapists, nutritionists and speech and language pathologists.

6.17 Each northern division council should establish a special subcommittee to assist in the management of community-based programs, with representatives from the council and senior staff of the Northern Health Services Branch.

(a) The subcommittee should work closely with Northern Health Services Branch personnel on recruitment, employee issues, budget allocations and program planning.

6.18 In order to provide more complete and expanded services, the staff resources allocated to community-based services in the North should be significantly increased.

(a) On the basis of the present population and health conditions, the following allocation of staff for provincially-funded programs in the North would appear appropriate:

public health and primary care nurses - 40
mental health workers - 8
community health workers/assistants - 30
public health inspectors - 3
physical and occupational therapists - 6
speech and language pathologists - 3
nutritionists - 3

6.19 To ensure adequate chiropody services to the North, a chiropody team should be established jointly by the three northern division councils.

(a) The team should be based in La Ronge and administrative responsibility for it assigned to the La Ronge Division Council.

(b) The team should provide services on a regular basis to all communities in the North.

6.20 The role of the community health worker should be significantly expanded in the provision of community-based services in the North.

(a) The community health worker's roles should be that of interpreter, liaison, educator and facilitator, particularly in the following areas:

- provision and co-ordination of home care services
- supervision of satellite clinics
- co-ordination of first responder teams

(b) A new position of **community health assistant** should be established to assist and support the community health worker.

6.21 **To effectively integrate alcohol and drug abuse treatment services into the community-based package, a northern arm of the restructured Saskatchewan Alcohol and Drug Abuse Foundation should be established.**

(a) The northern Saskatchewan Alcohol and Drug Abuse Foundation (SADAF) should be made up of the three division council chairpersons, the Executive Director of Northern Health Services Branch, and a senior official of the Medical Services Branch, Health and Welfare Canada.

(b) The northern SADAF should be responsible for the overall direction and co-ordination of alcohol and drug abuse services in the North.

(c) As with other community-based services, staff employed for the delivery of alcohol and drug abuse services should be recruited by SADAF and contracted to the individual division councils.

6.22 **A health education and promotion program specifically directed to northern residents should be jointly developed by the Northern Health Services Branch and the division councils.**

(a) The Northern Health Services Branch should be responsible for the initiation and direction of the program, and the division councils for its administration and delivery at the community level.

6.23 **A family counselling program to address the problems of teen pregnancy, family violence and sexually-transmitted diseases in the North should be jointly developed by Northern Health Services Branch and the division councils and administered by the councils.**

6.24 **Northern community organizations and volunteers should be encouraged by community-based administrators and staff to become involved in developing and implementing health projects and services at the community level.**

6.25 **A medical transportation system should be developed in Northern Saskatchewan which ensures a wide range of quality and cost-effective non-emergency and emergency medical transportation services within each division and throughout the North.**

(a) Division councils should be responsible for the provision of all medical transportation services, except air ambulance, within their respective divisions.

(b) There should be four categories of medical transportation:

(i) Non-emergency services which transport residents from their communities and homes to health care facilities, or between facilities on a non-emergency basis, and which do not require a specially-equipped vehicle or a qualified health professional in attendance.

(ii) Non-emergency and emergency ground ambulance services which require the attendance of a qualified health professional and/or special equipment in the transfer of patients.

(iii) Medivac services which utilize a variety of modes of transportation to facilitate emergency evacuations and transportation when a road or air ambulance is not available or practical.

(iv) Medical support transportation which utilizes the regular vehicles used for non-emergency medical transportation to transport such items as medical supplies and test specimens and results.

(c) Each division council should establish a central dispatch service at its division hospital.

(d) First responder teams consisting of community volunteers with a community health worker as team facilitator should be formed by each division council throughout its outlying communities.

6.26 Each northern division council should designate a medical transportation co-ordinator to approve and co-ordinate non-emergency medical transportation services, monitor and assess the appropriateness of emergency services initiated and provided, and co-ordinate and administer medivac services for the division.

6.27 A NORTHERN MEDICAL TRANSPORTATION AUTHORITY with headquarters in La Ronge should be established as a chapter of the Saskatchewan Medical Transportation Authority to ensure quality medical transportation services are available and accessible in all northern regions.

(a) Membership should consist of representatives of the northern division councils, the Northern Health Services Branch (Department of Health) and the Medical Services Branch (Health and Welfare Canada).

(b) The Authority should be chaired by a division council representative who will also serve as the northern representative on the Saskatchewan Medical Transportation Authority.

(c) Specific responsibilities of the Authority should include:

(i) The establishment and monitoring of ambulance service standards to ensure they are in accordance with provincially-established operating standards.

(ii) The ownership and management of the northern air ambulance program.

(iii) The development of "first responder" training programs for implementation by division councils.

6.28 Given its unique needs and geography, an air ambulance service should be established exclusively for the North and managed by the Northern Medical Transportation Authority.

(a) The Northern Medical Transportation Authority should arrange for the purchase, lease or rental of a suitably equipped and staffed aircraft to be located in La Ronge.

(b) Air ambulance services should be co-ordinated and dispatched through a central dispatch at the La Ronge Division Hospital.

(c) There should be firm protocols for the use of air ambulance services relative to medivac and ground medical transportation services.

6.29 A ground ambulance system which provides high-quality, cost-effective services and is responsive to the particular needs of individual northern communities should be developed by the La Ronge and Churchill River West divisions.

(a) The La Ronge Division should operate two ambulances located at La Ronge, and the Churchill River West Division should operate four ambulances centred in La Loche, Ile-à-la-Crosse, Buffalo Narrows and Beauval.

(b) Road ambulances should be staffed by qualified emergency medical technicians (EMTs and/or EMT-As) who will also assist in the home-base division hospital or family health care centre, whenever possible. Emergency medical personnel should be available to accompany air ambulance and medivac trips.

6.30 Each division council should provide non-emergency medical transportation services to northern residents needing to travel within or outside their communities for medical purposes, in situations when a specially-equipped vehicle and/or a qualified health professional is not required.

(a) Division councils should purchase, lease or rent vehicles such as vans, or contract the services of local transportation companies, to transport residents.

(b) All trips through this program should be initiated through and authorized by the division medical transportation co-ordinator.

(c) Residents utilizing the service should be charged a basic fee, determined on the basis of economy fares charged by commercial aircraft companies or the Saskatchewan Transportation Company, depending on whether travel is by road or air.

(d) The Department of Social Services and Health and Welfare Canada should be responsible for reimbursing the division councils for transportation costs incurred by social assistance clients and status Indians, respectively.

(e) The basic transportation services provided by this program should also be used to transport medical supplies, test specimens and results, etc. when feasible.

6.31 Quality medivac services should be a component of the comprehensive medical transportation system in the North, and complement air and road ambulance services.

(a) Division councils should be responsible for the provision and management of medivac services within their respective divisions.

(b) Division councils should enter into contracts with first-call medivac providers specifying standards, arrangements and payment rates.

6.32 In order to achieve consistency and equity in user charges, a standard pick-up and mileage fee should be established for all Saskatchewan residents using northern ground and air ambulance and medivac services, with a capping of charges regardless of distance, mode of transportation or patient age.

(a) The Department of Social Services and Health and Welfare Canada should be responsible for the payment of user charges on behalf of their respective clients.

6.33 The main base for medical practice in each northern division should

be the community in which the division hospital is located, and that practice should consist of a group of at least three physicians.

(a) Medical services to small communities should be provided through regular visits.

(b) The role of the primary care nurse as the initial contact for primary care services should be expanded in the smaller communities, with the necessary medical backup being provided by the physicians in the division centres.

6.34 **Northern division councils should have the primary responsibility for ensuring that adequate physician services are available within their divisions, through contractual arrangements with the College of Medicine, or through incentives for the establishment of a fee-for-service group practice, or a council-operated capitation practice such as a community clinic.**

6.35 **The College of Medicine, through the Northern Medical Services Unit, should provide a central recruitment support service for division councils in order to locate general practitioners and selected specialists who may be interested in practising medicine in northern communities.**

6.36 **The College of Medicine should continue and expand its services to increase itinerant specialist services to northern division hospitals and outlying communities, including co-ordination of detailed travel and administrative arrangements and orientation to northern cultures and circumstances.**

6.37 **Division councils, the College of Medicine and the Northern Health Services Branch should together be responsible for developing and maintaining an environment which provides medical practitioners with necessary professional support systems and benefits.**

(a) Situations and initiatives contributing towards an attractive practice environment should include:

- Adequately staffed and equipped division hospitals.
- First-class emergency response and ambulance systems.
- Access to itinerant specialist services.
- Sophisticated communication and diagnostic equipment which provides for transmission between the division hospitals and their satellites, and with major southern facilities.
- Development of medical research programs and activities in the North.
- Provisions for vacation and educational leave benefits.
- Adequate housing.

6.38 **The Department of Education, Northern Health Services Branch and northern division councils should jointly develop an aggressive program to make northern high school students aware of the need for native health care professionals in the new system and of the opportunities available to them.**

(a) The program may include such initiatives as career days, presentations by health care professionals, and student visits to health care facilities and programs within a division.

6.39 The proposed Health Manpower Branch of the Department of Health should develop a special focus on the manpower needs of the North, with the primary objective of encouraging northerners to train in the health care field.

(a) A special **northern manpower advisory committee** should be appointed by the Deputy Minister of Health to advise the Branch. Representation on this working group should include the Northern Health Services Branch; the Medical Services Branch, Health and Welfare Canada; northern division councils; the Department of Education; the University of Saskatchewan; and the Saskatchewan Institute of Applied Science and Technology. The Health Manpower Branch should serve the secretariat function.

(b) The Branch and the northern advisory advisory committee should jointly assess the northern manpower needs and the training programs that currently exist for northern residents, and develop a plan of action which will result in education programs that are co-ordinated, available and accessible to northern residents.

(c) Health career training programs developed through the Health Manpower Branch and its northern manpower advisory committee should be sensitive to the cultures and languages of northern students and should attempt to provide for classroom delivery in northern communities for at least the introductory levels of university and technical institute programs, such as nursing, physical therapy and nutrition.

(d) The Health Manpower Branch and the northern manpower advisory committee should ensure education training programs are available through northern high schools and other educational institutions such as community colleges, to provide students and adults with the necessary classes and upgrading to meet prerequisite requirements for health professional training programs.

6.40 The Department of Health, through the Northern Health Services Branch, should provide an incentives program to encourage northern residents to pursue health careers, with financial assistance toward the cost of training, books, travel and accommodation being a major element of the program.

(a) A return-in-service commitment to the North should be stipulated as a condition of any financial assistance.

6.41 Federal and provincial officials should work together to expand and revise the federal community health representative training program into a jointly-sponsored program which trains northern residents as community health workers and community health assistants.

(a) A one-year diploma program for community health workers should be headquartered in La Ronge.

(b) The first three months of the program should provide basic orientation to community health and should be offered in local communities. Successful completion of this portion should provide the necessary qualification for a community health worker assistant.

(c) The remaining nine months of the program should involve six months of classroom instruction followed by a three-month practicum in the student's community. Successful completion of the 12-month program should earn the community health worker qualification.

(d) A primary care nurse should supervise the course practicum.

(e) As their future employers, division councils should nominate the candidates for this program.

6.42 **Division councils, in co-operation with the Northern Health Services Branch, should develop summer employment opportunities within their programs and facilities to give students interested in health careers, opportunities for first-hand experience.**

6.43 **Institutions such as the University of Saskatchewan and the Saskatchewan Institute of Applied Science and Technology, which train health professionals, and the northern division councils should jointly develop a program which promotes and encourages health care student practicums in northern communities and institutions.**

6.44 **The Department of Health and the Public Service Commission should adopt human resources management policies which provide the Northern Health Services Branch with the authority and flexibility to staff its own positions and enable it to support the division councils in their recruitment efforts.**

(a) A human resources function should be established within the Northern Health Services Branch in La Ronge.

(b) The Northern Health Services Branch should develop a pro-active recruitment strategy which includes such activities as visits to in- and out-of-province campuses, and professional conferences.

6.45 **In order to recruit and retain health care professionals and support staff in northern communities and institutions, special compensation packages should be developed by the northern division councils and the Northern Health Services Branch.**

(a) Salary levels should be increased to equal or exceed what is paid by other health care employers in the North.

(b) Salary levels paid to northern employees should reflect the northern cost of living differential.

(c) Employees should receive a bonus upon completion of each year of service.

(d) A signing bonus with a return-in-service commitment should be paid in two instalments to all new employees during their first year of service.

6.46 **Northern division councils should be responsible for all matters related to staff housing and for ensuring adequate housing is available for staff when required.**

(a) Furnished rental units should be available to all northern staff, except those in La Ronge and Creighton.

(b) Housing and maintenance standards should be established and improved from current levels.

(c) Whenever possible, housing should consist of multiplex buildings rather than single dwellings.

6.47 **Employment policies and practices should take into account such factors as isolation and distances, and include provisions for leave with pay to accommodate special medical, rest and service needs.**

6.48 **Initiatives to enhance professional support for northern staff should be developed jointly by the Northern Health Services Branch and the northern division councils and should include a minimum amount of paid educational leave, regular professional conferences for northern staff, and communications technology linking professionals with each other and with other professional jurisdictions.**

6.49 **An orientation program that combines seminars, community visits and interviews with professionals practising in the North should be developed by the Northern Health Services Branch and the division councils to ensure all new staff are familiar with and sensitive to the cultures, needs and circumstances of the North.**

6.50 **To improve the dental health of the general northern population, the Children's Dental Program delivered through the Northern Health Services Branch - which provides basic dental services to children aged five to 13 - should be extended to make these same basic services available to northern residents of all ages.**

(a) The services should be delivered by teams of dental therapists and dental assistants, under the distance supervision and involvement of a dentist. A complement of six dental therapists, six dental assistants, two dentists and one equipment technician is expected to be required.

(b) Dental services for school-age children should continue to be school-based; services for pre-school children and adults should be provided at family health care centres.

(c) Legislation and regulations should be amended to allow dental therapists and assistants to deliver services in the absence of an on-site dentist.

(d) Arrangements should be worked out with the federal government to provide, through its existing program, training for dental therapists who would be employed by the Northern Health Services Branch to provide services to children and adults.

6.51 **Selective government subsidies should be developed to make basic, healthy foods accessible and affordable to all residents of Northern Saskatchewan.**

(a) Policies should clearly identify the foods to be subsidized and should exclude foods and related products with little or no nutritional value.

(b) The program should be based on the general principle that residents of Northern Saskatchewan should not be required to pay more for selected foods than southern residents.

(c) The subsidies should be only for foods bought for personal consumption and should exclude foods bought for profit by commercial establishments.

6.52 A NORTHERN SOCIAL POLICY SECRETARIAT with headquarters in La Ronge should be formed with representation from all government services which affect the health and well-being of northern residents.

(a) The secretariat's mandate, clearly defined in legislation, should be to examine all major proposals and plans of the departments represented, and to make recommendations to the respective deputy ministers based on their effects on northern people, their communities and their environment.

(b) The secretariat's members should be the executive directors responsible for northern health services in the fields of social services, education, housing, environment, industry, economic and recreational development and health.

(c) The secretariat should second a small staff from the departments represented to co-ordinate information, analyse proposals and communicate about specific projects.

(d) The secretariat should report annually to the Deputy Minister to the Premier, the division councils and the deputy ministers of each department represented.

6.53 In order to achieve a comprehensive health care system for all residents of the North, federal and provincial health services should be combined and responsibility for their delivery assigned to the division councils on behalf of all residents of their divisions.

(a) A panel of provincial and federal officials should be established to examine and identify the services and programs that can be amalgamated.

(b) In order to achieve the objective of a single system, a planning and implementation committee should be established, consisting of one status and one non-status resident from each division, plus representatives from the Northern Health Services Branch and the Medical Services Branch of Health and Welfare Canada.

(c) Federal and provincial co-operation and co-ordination should be pursued in:

  (i) funding the development, construction and operation of division facilities.

  (ii) delivery of community-based programs and ambulance services.

  (iii) establishment of education programs for health care professionals and paraprofessionals.

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La Loche
La Ronge
Stony Rapids
Uranium City

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Yorkton

Briefs Presented to the Saskatchewan Commission on Directions in Health Care at its Public Hearings

Allergy Foundation of Canada, Regina
Amies, Dr. David, Moose Jaw
Approved Private Homes Inc., North Battleford
Arm River Housing Corporation and Davidson Union Hospital
Armstrong, Dr. G.H., Estevan
Arthritis Society, Saskatchewan Division, Regina
Assiniboia Union Hospital
Assiniboia, Town of
Associated Respiratory Services, Saskatoon
Axworthy, Chris, M.P.
Balcarres Union Hospital
Baltzan, Dr. M.A., Saskatoon
Base Hospitals Chief Executive Officers
Battlefords Regional Care Centre, The
Battlefords Alcohol and Drug Abuse Corporation
Battlefords and District Home Care #24
Battlefords Area Municipal Road Ambulance District Association
Battlefords Right to Life Organization,
Battlefords Union Hospital
Battlefords Union Hospital Medical Staff
Beechy Social Club
Beechy Union Hospital
Bell, Joan, Prince Albert
Biggar and District Home Care Board Inc. #22
Birch Hills Health Care Agencies
Boan, Jack, Regina
Bockus, Sherry, Saskatoon
Breast Feeding Management Services, Saskatoon
Briercrest Bible College, Caronport and Village of Caronport
Brown, Garnet, Prince Albert
Bruno and District Nursing Home Committee
Buena Vista Lodge Board of Directors, Kerrobert
Cabri Union Hospital
Canadian Anesthetists' Society, Saskatchewan Division
Canadian Association of Radiologists, Saskatchewan Division
Canadian Cancer Society, Saskatchewan Division
Canadian Cancer Society, Southwest Unit
Canadian Co-operative Association, Saskatchewan Region
Canadian Cystic Fibrosis Foundation
Canadian Diabetes Association, Saskatchewan Division
Canadian Drug Manufacturers Association
Canadian Food Service Supervisors Association, Saskatchewan Chapter
Canadian Institute of Public Health Inspectors, Saskatchewan Branch
Canadian Mental Health Association in Saskatchewan
Canadian National Institute for the Blind, Regina
Canadian Physiotherapy Association, Saskatchewan Branch
Canadian Red Cross Society, Saskatchewan Division
Canadian Society of Hospital Pharmacists, Saskatchewan Branch
Canadian Union of Public Employees Local #83, Battlefords Union Hospital

Canadian Union of Public Employees Local #482, Weyburn
Canadian Union of Public Employees Local #1481, Gravelbourg
Canadian Union of Public Employees Local #1940, Radville
Canadian Union of Public Employees Locals #81 and 84, Prince Albert
Canadian Union of Public Employees, Saskatchewan Division
Candlelighters of Saskatoon
Canning, Doug and Karen, Hudson Bay
Capp, Dr. Robert, Wascana Rehabilitation Centre, Regina
Catholic Health Association of Saskatchewan
Catholic Health Council of Saskatchewan
Catholic Health Council, St. Joseph's Hospital, St. Martin's Hospital
Certified Nursing Assistants, Cut Knife Union Hospital
Chartier, Rusty, Saskatoon
Mitchell, Don, Moose Jaw
Children North Early Intervention Program, La Ronge
Chiropractors' Association of Saskatchewan
First United Church, Swift Current
Cobb, Mavis, Wroxton
College of Dental Surgeons of Saskatchewan, Saskatoon
College of Family Physicians of Canada, Saskatchewan Chapter
College of Physicians and Surgeons of Saskatchewan, Saskatoon
Community Health Cooperative Federation of Saskatchewan
Community Health Nurses Professional Practice Group (SRNA), Saskatoon
Community Health Services Association (Regina) Ltd.
Community Health Services Branch, Regional Board Chairpersons,
    Saskatchewan Health, Prince Albert
Concerned Citizens of the Battlefords and West Central Area
Concorde Group of Companies / Home Health Care Inc. (HHC), Edmonton
Coney, Elaine and Feltmate, Rev. Dana, Gainsborough
Consumers' Association of Canada, Saskatchewan Branch, La Ronge
Consumers' Association of Canada, Saskatchewan Branch, Saskatoon
Co-operators Data Services Limited (CDSL), Regina
Coronach Union Hospital
Crocus Co-operative, Saskatoon
Crocus Co-op Former Board Members, Saskatoon
Cumberland House, Northern Village of
Denturist Society of Saskatchewan
Dill, Kathy, North Battleford
District #35 Healthcare Co-ordinating Committee, Canora
Dodsland Union Hospital Board of Directors
Donnelly, Glenn, Hooper, Patricia and Beach, Aurelia, Regina
Eagle, Ken and Jean, Saskatoon
Early Childhood Intervention Program Provincial Council, Saskatoon
Eatonia Union Hospital
Educators in Suicide Prevention (ESP) and Canadian Association
    for Suicide Prevention (CASP)
Elder, Harry, Fillmore
Elizabeth Fry Society of Saskatchewan
Espenant, Connie, Hudson Bay

Estevan and Weyburn Committee Against Family Violence
Estevan Area Home Care District 9 Inc.
Eston Union Hospital
Extendicare Health Service Inc., Saskatoon
Extendicare Hospital Management and Development Ltd., Markham, Ontario
Faith and Sharing, Saskatoon
Family Service Bureau of Regina
Federation of Saskatchewan Indian Nations (FSIN)
Fillmore/Stoughton District Co-ordinating Committee - Screening Committee
Fitzsimmons, Michael and Watson, Colleen, Prince Albert
Flett, Neil and Lois, Nipawin
Fort Pelly-Livingstone District #34 Home Care Corporation, Pelly
Fowler, John, Arborfield
Gabriel Dumont Institute, Prince Albert
George Bailey Centre, Humboldt
Geriatric Reenablement Unit of Parkridge Centre, Saskatoon
Grasslands Home Care District # 2, Maple Creek
Green Lake, Northern Village of
Greenhead District #23 Home Care Corporation, Unity
Grenfell Health Care Agencies
Gull Lake and District Special-care Home Ltd.
Gull Lake Union Hospital Board
Haggerty, Sam, Regina
Harris, Dr. A.L., Saskatoon
Health Care Ladies Auxiliary, Beechy
Health Care Planning Committee of Swift Current
Health Sciences Association of Saskatchewan, Saskatoon
Health Systems Support Group Inc., Saskatoon
Healthy Horizons Association, Fort Qu'Appelle
Helping Hands Healthcare Inc., Regina
Hjertaas, Dale and Paule, Regina
Hjertaas, Ralph, Prince Albert
Holy Family Hospital and Victoria Union Hospital, Prince Albert
Home Care Saskatoon District #45, Inc.
Houston, Dr. Stuart, Saskatoon
Humanitas - Saskatoon Palliative Care Inc.
Humboldt and District Interagency Group
Ile-à-la-Crosse, Northern Village of
Imperial Union Hospital
Indian and Inuit Nurses of Canada, Regina
Ituna and District Pioneer Lodge
Johnson, Evelyn, Estevan
Juvenile Diabetes Foundation Canada, Saskatoon Chapter
Kamsack and District Nursing Home
Kelvington Union Hospital
Kerrobert Union Hospital, Board of Directors
Kindersley Union Hospital
Kipling District Coordinating Committee, Kipling Memorial Union Hospital
Klusa, Valerie and Sinnett, Gail, Saskatoon

La Ronge Hospital
La Ronge Kinsmen Club
La Ronge Medical Clinic
La Ronge Native Women's Council
La Ronge, Town of
Lady Minto Union Hospital, Edam
Lakeside Manor Care Home, Saltcoats
Langenburg and District Co-ordinating Committee
Lanigan Regional Home Care District #13 Inc.
Leader Union Hospital
Leather River Women's Institute, Tisdale
LeBlanc, Claude, St. Louis
Leppard, Morley, Prince Albert
Liaison Committee in Support of the Handicapped, Regina
Lloydminster, City of
Lupus Erythematosus Society of Saskatchewan Inc., Prince Albert Chapter
Lupus Erythematosus Society of Saskatchewan Inc., Saskatoon
Lutheran Sunset Home Inc. of Saskatoon
Maple Creek Union Hospital
Matti, Dr. Edward, Saskatoon
McCorriston, Mel, Nipawin
McHattie, Dr. James, Regina
McKeown, Joe, Regina
McQuatt, Elaine, Humboldt
Meadow Lake Tribal Council
Meadow Lake Union Hospital
Melfort and District Home Care #32 Inc.
Melfort Union Hospital
Mennonite Home for the Aged, Rosthern
Mental Health Association in Saskatchewan, Battlefords Branch
Mental Health Association in Saskatchewan, Humboldt Branch
Mental Health Association in Saskatchewan, Kindersley Branch
Mental Health Association in Saskatchewan, La Ronge Branch
Mental Health Association in Saskatchewan, Lloydminster Branch
Mental Health Association in Saskatchewan, Melfort Branch
Mental Health Association in Saskatchewan, Moose Jaw Branch
Mental Health Association in Saskatchewan, Nipawin Branch
Mental Health Association in Saskatchewan, Prince Albert Branch
Mental Health Association in Saskatchewan, Regina Branch
Mental Health Association in Saskatchewan, Saskatoon Branch
Mental Health Association in Saskatchewan, Swift Current Branch
Mental Health Association in Saskatchewan. Weyburn Branch
Mental Health Association in Saskatchewan, Yorkton Branch
Mental Health Coalition, Prince Albert
Meredith Moore and Associates, La Ronge
Merici Centre For Infant Development, Regina
Michel Village, Northern Hamlet of
Midwives Association of Saskatchewan, Nipawin
Midwives Association of Saskatchewan, Prince Albert

Millette, Marceline, Estevan
Missinipe, Northern Hamlet of
Moose Jaw Area Municipal Road Ambulance District Association Board
Moose Jaw Assessment and Coordination Committee
Moose Jaw Citizens for Reproductive Rights
Moose Jaw Providence Hospital
Moose Jaw Right to Life
Moosomin District Health Care Committee
Murdoch, Deb and Gessell, Betty, Saskatoon
National Farmers Union Region 6, Saskatoon
Native Council of Canada
Nelson, Kathy, Glentworth
New Hope Pioneer Lodge, Stoughton
Newton, Robert, Meadow Lake
Nightingale Home Help, Saskatoon
Nipawin and District Coordinating Committee
Nipawin and District Home Care 31 Inc.
Nipawin and District Regional Ambulance District Board
Nipawin Ambulance Service
Nipawin Union Hospital
Nipawin Union Hospital Medical Staff
Nordlund, Shirley, Tisdale
North American Chronic Pain Association of Canada
North Battleford and District Medical Society
North-East Early Childhood Intervention Program, Tisdale
Northern Lights School Division No. 113, La Ronge
Northern Lights School Division No. 113, Prince Albert
Nurses for Life, Regina
Ohrt, Gerald A., Caronport
Olesen, Dr. Mavis, Regina
Oliver Lodge Board of Directors, Saskatoon
Parkland Ambulance Care Ltd., Prince Albert
Parkland Early Childhood Intervention Program Inc., Yorkton
Parkland Regional Care Centre, Melfort
Patterson, Bob, Swift Current
Personal Care Homes Association, Saskatoon
Pharmaceutical Manufacturers Association of Canada
Phoenix Residential Society, Regina
Pine Island Lodge Ltd., Maidstone
Pinehouse Northern Village, Pinehouse Lake
Planned Parenthood Saskatchewan, Regina
Portage Self Help Group Inc., North Battleford
Preeceville/Sturgis Health Care Providers
Prince Albert and District Council on Aging
Prince Albert and District Medical Society
Prince Albert Area Municipal Road Ambulance District Board
Prince Albert Community Clinic Cooperative Health Centre
Prince Albert Cooperative Health Centre, Medical Health Staff
Prince Albert District Chiefs

Prince Albert Pineland District No. 28 Home Care Inc.
Pro-Life Association Inc., Regina
Pro-Life Association, Estevan and District
Pro-Life Association, Melfort and District
Pro-Life Association, Weyburn
Pro-Life Organization, Prince Albert
Project to Improve Victim Services in Regina
Psychological Society of Saskatchewan
Pyett, Clare and Vi, Melfort
Ramsay, James, Humboldt
Redvers Union Hospital
Regina and District Dental Society
Regina and District Medical Society
Regina Area Municipal Road Ambulance District
Regina Assessment and Placement Service
Regina Board of Education (School Division No. 4)
Regina Citizens for Reproductive Choice
Regina Council on Aging
Regina Daycare Directors Inc.
Regina District Society for the Autistic
Regina General Hospital
Regina Obstetrics and Gynecology
Regina Palliative Care Inc.
Regina Physical Therapists in Long Term Care
Regina, City of
Robson, C. A. (Smokey), Saskatoon
Rodger, Dr. David E., Regina
Rosetown and District Health Centre
Rosetown/Kindersley District Medical Society
Rural Municipality of Buckland #491
Rural Municipality of Flett's Springs #429, Pathlow
Rural Municipality of Porcupine #395
Rural Municipality of Wilton #472, Marshall (Beamish, Leona)
Rye, Dr. John, Prince Albert
S.C.E.P. Centre Society, Regina
Sand Hills Home Care District #1 Inc., Leader
Santa Maria Senior Citizens Home, Regina
Sask Sport Inc., Saskatchewan Council of Cultural Organizations,
    Saskatchewan Parks and Recreation Association
Saskatchewan Abilities Council
Saskatchewan Action Committee, Status of Women, North Battleford
Saskatchewan Action Committee, Status of Women, Swift Current
Saskatchewan Action Committee, Status of Women, Regina
Saskatchewan Alcohol and Drug Abuse Commission
Saskatchewan Alzheimer's and Related Diseases Association, Carrot River Chapter
Saskatchewan Alzheimer's and Related Diseases Association, Regina General Hospital
Saskatchewan Ambulance Association
Saskatchewan Approved Private Care Homes Inc.
Saskatchewan Association for Community Living

Saskatchewan Association of Certified Nursing Assistants
Saskatchewan Association of Chiropodists
Saskatchewan Association of Combined Laboratory and X-Ray Technicians
Saskatchewan Association of Health Services Executives
Saskatchewan Association of Optometrists
Saskatchewan Association of Pathologists
Saskatchewan Association of Rehabilitation Centres
Saskatchewan Association of Respiratory Therapists
Saskatchewan Association of Rural Municipalities
Saskatchewan Association of Social Workers
Saskatchewan Association of Special Care Homes
Saskatchewan Association of Speech-Language Pathologists and Audiologists
Saskatchewan Cancer Foundation
Saskatchewan Cerebral Palsy Association
Saskatchewan Child Care Association Inc.
Saskatchewan Dental Assistants' Association
Saskatchewan Dental Hygienists Association
Saskatchewan Dental Therapists Association
Saskatchewan Dietetic Association
Saskatchewan Federation of Labour
Saskatchewan Friends of Schizophrenics
Saskatchewan Gerontology Association
Saskatchewan Government Employees' Union
Saskatchewan Head Injury Association, Kincaid
Saskatchewan Head Injury Association, Regina Chapter
Saskatchewan Head Injury Association, Saskatoon
Saskatchewan Health Coalition
Saskatchewan Health Research Board
Saskatchewan Health-Care Association
Saskatchewan Heart Foundation Inc.
Saskatchewan Home Care Association
Saskatchewan Institute of Applied Science and Technology (Diploma
  Nursing Program), Kelsey Campus, Saskatoon
Saskatchewan Institute on Prevention of Handicaps
Saskatchewan Interagency Council on Smoking and Health Inc.
Saskatchewan Interfaith Pastoral Care Association
Saskatchewan Lung Association
Saskatchewan Medical Association
Saskatchewan Ophthalmic Dispensers Association
Saskatchewan Pharmaceutical Association
Saskatchewan Psychiatric Nurses Association
Saskatchewan Psychological Association
Saskatchewan Public Health Association Inc.
Saskatchewan Public Health Nurses Association
Saskatchewan Reflexology Association Inc.
Saskatchewan Registered Nurses' Association, Esterhazy Chapter
Saskatchewan Registered Nurses' Association, Estevan Chapter
Saskatchewan Registered Nurses' Association, Humboldt Chapter
Saskatchewan Registered Nurses' Association, Melville Chapter

Saskatchewan Registered Nurses' Association, Nipawin Chapter
Saskatchewan Registered Nurses' Association, Preeceville Chapter
Saskatchewan Registered Nurses' Association, Regina Chapter
Saskatchewan Registered Nurses' Association, Saskatoon Chapter
Saskatchewan Registered Nurses' Association,
  Spiritwood-Rabbit Lake-Leoville Chapter
Saskatchewan Registered Nurses' Association, Yorkton Chapter
Saskatchewan Safety Council
Saskatchewan School Trustees Association
Saskatchewan Senior Fitness Association Inc.
Saskatchewan Seniors Association Inc. - Nipawin Branch
Saskatchewan Society of Medical Laboratory Technologists Inc.
Saskatchewan Society of Occupational Therapists
Saskatchewan Teachers' Federation
Saskatchewan Union of Nurses Local #43, Yorkton
Saskatchewan Union of Nurses Local #101, St. Paul's Hospital, Saskatoon
Saskatchewan Union of Nurses Local #105, Pasqua Hospital, Regina
Saskatchewan Union of Nurses Local #106, Regina General Hospital
Saskatchewan Union of Nurses, Lloydminster
Saskatchewan Union of Nurses, Saskatoon
Saskatchewan Voice of the Handicapped
Saskatoon and District Dental Society
Saskatoon Approved Private Care Homes Inc.
Saskatoon Area Ambulance District
Saskatoon Catholic Board of Education
Saskatoon City Hospital
Saskatoon Community Health Services Association
Saskatoon Community Health Unit
Saskatoon Council of Women
Saskatoon Crisis Intervention Service
Saskatoon District Co-ordinating Committee
Saskatoon District Tribal Council
Saskatoon Home Support Services
Saskatoon Housing Coalition Inc.
Saskatoon Local Church Leaders' Group
Saskatoon Mental Health Advisory Committee
Saskatoon Society for Autism
Schnurr, Dr. Joe, Saskatoon
Scriver, Barbara, Nipawin
Self Help and Recreation/Education (SHARE), Prince Albert Inc.
Senior Citizens "Action Now" Inc., North Battleford
Senior Citizens Action Now Local 276, Moose Jaw
Senior Citizens' Provincial Council
Senior Citizens' Service of Regina, 1987 Ltd.
Service Employees' International Union (SEIU)
Shaunavon Union Hospital
Sherbrooke Community Centre, Saskatoon
Sime, Dr. M.O., Yorkton
Smith, Pat, MLA, Swift Current

Souris Valley Regional Care Centre, Weyburn
South Country Home Care District No. 7, Willow Bunch
South End, Village of
South Saskatchewan Hospital Centre, Regina
South Saskatchewan Hospital Centre (Nursing Administration), Regina
Southwest Community Lodge/Southwest Nursing Home, Shaunavon
Southwest District Co-ordinating Committee, Shaunavon
Southwest Pro-Life Association, Swift Current
St. Ann's Senior Citizens Village Corporation, Saskatoon
St. Anthony's Hospital, Esterhazy
St. Joseph's Hospital, Estevan
St. Joseph's Hospital, Gravelbourg
St. Joseph's Union Hospital, Lestock
St. Paul's Hospital (Grey Nuns of Saskatoon)
St. Peter's Hospital, Melville
St. Walburg Union Hospital/Lakeland Lodge Inc.
Spalding Union Hospital
Squirrel Hills Home Care District #14 Inc., Indian Head
Stony Rapids, Northern Settlement of
Sturgis and District Special Care Home Steering Committee
Swift Current and District Medical Society
Swift Current District Coordinating Committee
Swift Current Head Injury Association
Swift Current Long-Term Health Care Planning Committee
Swift Current Senior Citizens Activity Centre
Taylor, Alex, Regina
Teen-Aid, Moose Jaw
Thunder Creek Home Care District #6 Inc., Moose Jaw
Thunder Creek Rehabilitation Association Inc., Moose Jaw
Tisdale Union Hospital
Touchwood-File Hills Qu'Appelle District Chiefs Council, Regina
Twanow, Dr. Richard and Webb, Dr. Robb, Melfort
Twin Rivers Home Care Inc., Lloydminster
United Church Housing Corporation (Mutchmor Lodge), Regina
Unity District Coordinating Committee
Unity Union Hospital
University Hospital, Saskatoon
University Hospital: Department of Family Medicine
University Hospital: Nuclear Medicine Department
University Hospital: Rehabilitation Outreach Services
University of Regina: Seniors' University Group Inc.
University of Regina: Social Administration Research Unit
University of Saskatchewan: College of Dentistry
University of Saskatchewan: College of Medicine
University of Saskatchewan: College of Medicine (Centre for Agricultural Medicine)
University of Saskatchewan: College of Nursing
University of Saskatchewan: College of Nursing (Educational Needs of Nurse Administrators)
University of Saskatchewan: College of Pharmacy

University of Saskatchewan: College of Physical Education
University of Saskatchewan: Department of Psychiatry
University of Saskatchewan: School of Physical Therapy
University of Saskatchewan: Student Health Centre
Uranium City Municipal Hospital
Victorian Order of Nurses, Prince Albert
Visvanathan, Dr. K.R., Estevan
Wahba, Dr. Y.S., Estevan
Wascana Home Care District #15, Regina
Wascana Rehabilitation Centre, Parents Support Group, Regina
Wascana Rehabilitation Centre, Regina
Watson Union Hospital
Wawota/Maryfield Group
We Care Health Services, Winnipeg, Manitoba
Western Senior Citizens Home, Leader
Weyburn and Area Council on Child Abuse
Weyburn and Area Health Services Planning Council
Weyburn and Area Home Care District #8 Inc.
Weyburn and District Special Care Homes Corporation
Weyburn District Coordinating Committee
Weyburn Union Hospital
White Mud Home Care District #4 Inc., Shaunavon
Whitespruce Youth Treatment Centre, Yorkton
Whitewood and District Nursing Home Inc.
Wynyard and District Community Health Services Association
Yorkton and District Home Care #36
Yorkton Union Hospital
Yorkton, City of

Special Note

During more than six months of hearings held across the province, over 450 briefs were publicly presented to the Commission. In addition, another approximately 150 were submitted to the Commission which were not presented at the public hearings. The variety and extensiveness of the briefs have been essential to the Commission's analysis and deliberations and the efforts of all the organizations and individuals who contributed to the review of the health care system of Saskatchewan are greatly appreciated.

GLOSSARY

Glossary of Terms

Acute care - Care or treatment for illness or injury, usually of short duration, requiring concentrated attention by health care practitioners.

Allied health professionals - Persons with special training in fields related to medicine, such as physical therapy, occupational therapy, speech and language pathology, all of whom work with physicians and other health professionals.

Ancillary health professions - Emergency medical technicians, certified nursing assistants, registered respiratory therapists and others with special training who work under the direction of health professionals.

Average daily census (ADC) - The number of people in hospital on the average day, calculated on an annual basis.

Capitation funding - A method of paying physicians and other health care professionals a negotiated sum, on a regular basis (usually annually), for a comprehensive set of services delivered to a specified population, based on the number of patients and their age-sex distribution.

Demographics - The statistical data describing a human population in terms of age, sex, marital status and other characteristsics.

Distance supervision - The supervision of a student, usually on a practicum or field experience, or a paraprofessional, by a designated professional at a base location.

Durable power of attorney - The legal authority for an individual named on behalf of another to make financial and health care decisions in the event the person who has granted that authority is not able to make such decisions on his or her own behalf.

Epidemiology - The study of determinants of health and disease in human population, including incidence, distribution and control of disease.

Fee-for-service payment - A form of reimbursement through which a health professional is paid a certain amount per procedure or service performed according to a schedule of fees; this is the predominant form of physician reimbursement under the Medical Care Insurance Plan.

Global budgeting - An arrangement whereby an annual all-inclusive sum is allocated an organization by a funding agency for all the services to be provided by the organization.

Group Home - A residence which is licensed and funded by the Department of Health and/or the Department of Social Services and which provides supportive living accommodations for the mentally ill, the mentally handicapped or the physically disabled (includes the 'approved homes' designation).

Heavy care - A term popularly used to describe the care given to residents of long-term care institutions such as supportive care centres (nursing homes) who require the most extensive nursing and support services, and often referred to as Level III and IV.

In-service education - Education offered by an employing agency to its staff.

Inpatient care - Care provided to people while they are in hospital.

Life expectancy - A statistical projection of the number of years an individual is expected to live, calculated from birth or other age.

Lithotripter - Medical equipment which uses sound waves, rather than surgery, to treat kidney stones.

Living will - A statement, prepared when an individual is well, which attests to that person's wish about measures to be taken to prolong life in the event that person becomes critically ill, and unable to make an informed decision at that time.

Medical Care Insurance Branch - The branch of the Department of Health responsible for administering the Medical Care Insurance Plan, which provides coverage for insured physician, optometrist, dental and chiropractic services.

Medivac - A variety of modes of transportation used to facilitate emergency evacuations and transportation when a road or air ambulance is not available or practical.

Mortality rate - The numbers of persons who die within a specified time within a defined population, usually defined by age, sex or cause of death, or all three.

Occupational therapy - A method of rehabilitation that seeks to restore, develop or maintain the task performance skills of persons physically or mentally impaired, to assist them to return to everyday life.

Orientation - On-the-job skill training which the employer provides to assist the employee to perform duties in a particular setting.

Palliative care - Involves active compassionate therapy for patients with terminal illness, in an effort to provide a pain-free but alert condition, and social, psychological and spiritual support for patient and family.

Paraprofessional - A trained aide who assists a health professional.

Personal care home - A private residence approved by the Department of Health to accommodate a limited number of people requiring supportive living arrangements.

Physical therapy - A method of treating disease or impaired motion through physical methods such as exercise, heat massage, hydrotherapy, or mechanical devices.

Practicum - A period of training which gives a student the opportunity to apply concepts learned in the classroom in a practical setting, under the supervision of a qualified professional.

Primary care - The first level of medical care when a patient visits a physician or other health professional for any (usually undifferentiated) symptom, complaint, condition or problem.

Quaternary care - A very specialized level of hospital treatment, either experimental in nature (e.g. liver transplants) or very rare (bone marrow transplants).

Rated bed capacity - The number of beds in a hospital which are appropriately equipped and staffed to receive patients.

Respite care - Patient care provided intermittently in the home or institution in order to provide temporary relief to the family/friend providing continuous care to the patient in the home.

Secondary care - A level of medical care requiring consultation or management by specialists to whom primary care physicians refer patients.

Separation - The technical term used to indicate discharge from the hospital. It includes people transferred from a hospital to other health care facilities and those who die in hospital.

Supportive care centre - An institution accommodating residents who require heavy care over extended periods of time.

Supportive living services (home care) - Health and other support services provided in the homes of the elderly, disabled, sick or convalescent, including nursing care, meals, homemaker services, assessment and care co-ordination, home maintenance, and rehabilitation services, which assist the individual to live at home.

Tertiary care - A level of medical care which requires highly specialized and narrowly focused skills, technology and support personnel and facilities, or which is required for rare, unusually complicated cases or extremely ill patients who cannot be cared for at the primary and secondary levels of care.

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